SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Family Heritage Life Insurance Company of America

Product Name: Individual Specified Disease Policy	SERFF Tr Num: FHLA-126785089	State: Arkansas
TOI: H07I Individual Health - Specified Disease - - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num: 46624
Sub-TOI: H07I.002A Dread Disease - Cancer Only	Co Tr Num: C8POLRAR	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Authors: Kevin Wicktora, Ruth Campanelli	Disposition Date: 09/07/2010
	Date Submitted: 08/26/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 01/11/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 09/07/2010	Explanation for Other Group Market Type:
	State Status Changed: 09/07/2010
Deemer Date:	Created By: Kevin Wicktora
Submitted By: Kevin Wicktora	Corresponding Filing Tracking Number:

Filing Description:

Rosalind Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
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TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

RE: Family Heritage Life Insurance Company of America NAIC # 77968
New Policy & Rate Filing – Individual Cancer Insurance Policy
Form Number: C8POLRAR

Dear Ms. Minor:

Family Heritage Life Insurance Company of America would like to submit the following forms and rates for your review and approval:

Form Number.....Description
C8POLRAR.....Cancer Policy
I8RID-EAR.....Intensive Care Unit Rider
C8APP-AR.....Application
C8EXR-ST.....Exclusion Rider
C8CHG-ST2.....Cancer Policy Change Form
C8OOCRST.....Outline of Coverage
C8CLM-ST.....Claim Form
C8UIR-ST.....Underwriting Information Release
C8AOC-ST.....Acknowledgement of Supplemental Coverage

This individual cancer insurance policy will be marketed primarily on a direct basis through licensed agents. The applicant will have a choice of three benefit plans, Standard, Preferred or Elite. Benefit dollar amounts are stated throughout the policy in the following order from left to right: Standard Level/Preferred Level/Elite Level. The policy issued will include only the benefit amounts for the selected plan.

The ICU Rider will available with daily benefit levels ranging from $300 to $1,800. The rider issued will display only the benefit amount for the level selected. The question on the application regarding policy issue via the internet is variable and may or may not appear on the application that is eventually printed.

Included in this filing are the following:

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

•This cover letter;
•Each of the referenced forms;
•An actuarial memorandum and premium rates for the policy;
•A Flesch Certification;
•A Certification of Compliance with Rule & Regulation 19; and
•Copies of previously approved forms we issue to satisfy Rule & Regulation 49 and the Consumer Information Notice requirement.

The filing fee is being submitted via EFT.

If you have any questions or require any additional information, please contact me at (440) 922-5134 or via e-mail at kevin.wicktora@familyheritagelife.com. Thank you for your assistance with this filing.

Sincerely,

Kevin R. Wicktora
Compliance Manager

Company and Contact

Filing Contact Information

Kevin Wicktora, Compliance Manager	kevin.wicktora@familyheritagelife.com
6001 East Royalton Road	440-922-5134 [Phone]
Suite 200	
Cleveland, OH 44147	

Filing Company Information

Family Heritage Life Insurance Company of America	CoCode: 77968	State of Domicile: Ohio
6001 East Royalton Road	Group Code:	Company Type: Life & Health
Suite 200	Group Name:	State ID Number:
Cleveland, OH 44147	FEIN Number: 34-1626521	
(440) 922-5200 ext. [Phone]		

Filing Fees

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Fee Required?	Yes
Fee Amount:	$550.00
Retaliatory?	No
Fee Explanation:	9 forms @ $50 per form = $450 2 rate sets @ $50 per set = $100 Total = $550
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Heritage Life Insurance Company of America	$550.00	08/26/2010	39046673

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/07/2010	09/07/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	09/02/2010	09/02/2010	Kevin Wicktora	09/03/2010	09/03/2010

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/07/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
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Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form *(revised)*	Individual Cancer Policy	Approved-Closed	Yes
Form	Individual Cancer Policy	Replaced	Yes
Form	Intensive Care Unit Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Exclusion Rider	Approved-Closed	Yes
Form	Policy Change Application	Approved-Closed	Yes
Form *(revised)*	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Form	Claim Form	Approved-Closed	Yes
Form	Underwriting Information Release Authorization	Approved-Closed	Yes
Form	Acknowledgement of Supplemental Coverage	Approved-Closed	Yes
Rate	Cancer Policy Rate Sheet	Approved-Closed	Yes
Rate	Intensive Care Unit Rider Rate Sheet	Approved-Closed	Yes

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
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Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/02/2010
Submitted Date	09/02/2010
Respond By Date	

Dear Kevin Wicktora,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Cancer Policy, C8POLRAR (Form)
- Outline of Coverage, C8OOCRST (Form)

Comment: As required by Rule 18, APPENDIX 1. (A) (3), specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s), directly caused or aggravated by the speficied disease(s) or the treatment of the specified disease(s).

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/03/2010
Submitted Date	09/03/2010

Dear Rosalind Minor,

Comments:
Thank you for your review of the subject filing.

Response 1

Comments: In order to comply with Rule 18, APPENDIX 1. (A) (3) we have added wording to the policy and outline of coverage that we have included in our previously approved Arkansas cancer policies. We apologize for not having included this wording in the initial forms.

A sentence has been added to the CANCER TREATMENT ONLY (Section 4 LIMITATIONS AND EXCLUSIONS) of the policy and outline. The new paragraph reads in its entirety as follows:

CANCER TREATMENT ONLY: This policy provides benefits only for loss due to Cancer and for Your Covered Cancer Treatment which occurs more than 30 days after the Effective Date of Your policy. This includes conditions or diseases caused or aggravated by or resulting from Cancer or Cancer Treatment.

As a result of this change, the outline has a new form number. The new form number is C8OOCRAR.

Related Objection 1

Applies To:

- Individual Cancer Policy, C8POLRAR (Form)
- Outline of Coverage, C8OOCRST (Form)

Comment:
As required by Rule 18, APPENDIX 1. (A) (3), specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s), directly caused or aggravated by the speficied disease(s) or the treatment of the specified disease(s).

Changed Items:

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Cancer Policy	C8POLRAR		Policy/Contract/Fraternal Certificate	Initial			C8POLRAR.pdf
Previous Version							
Individual Cancer Policy	*C8POLRAR*		*Policy/Contract/Fraternal Certificate*	*Initial*			C8POLRAR.pdf
Outline of Coverage	C8OOCRAR		Outline of Coverage	Initial			C8OOCRAR.pdf
Previous Version							
Outline of Coverage	*C8OOCRST*		*Outline of Coverage*	*Initial*			C8OOCRST.pdf

No Rate/Rule Schedule items changed.

We hope that we have responded to your objection satisfactorily. Should you have any additional questions or concerns, please let us know.

Sincerely,
Kevin Wicktora, Ruth Campanelli

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: C8POLRAR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/07/2010	C8POLRAR	Policy/Contract/Fraternal Certificate	Individual Cancer Policy	Initial			C8POLRAR.pdf
Approved-Closed 09/07/2010	I8RID-EAR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Intensive Care Unit Rider	Initial			I8RID-EAR.pdf
Approved-Closed 09/07/2010	C8APP-AR	Application/Enrollment Form	Application	Initial			C8APP-AR.pdf
Approved-Closed 09/07/2010	C8EXR-ST	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Exclusion Rider	Initial			C8EXR-ST.pdf
Approved-Closed 09/07/2010	C8CHG-ST2	Application/Enrollment Form	Policy Change Application	Initial			C8CHG-ST2.pdf
Approved-	C8OOCRA	Outline of	Outline of Coverage	Initial			C8OOCRAR.

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Closed 09/07/2010	R	Coverage				pdf
Approved-Closed 09/07/2010	C8CLM-ST	Other	Claim Form	Initial		C8CLM-ST.pdf
Approved-Closed 09/07/2010	C8UIR-ST	Other	Underwriting Information Release Authorization	Initial		C8UIR-ST.pdf
Approved-Closed 09/07/2010	C8AOC-ST	Other	Acknowledgement of Supplemental Coverage	Initial		C8AOC-ST.pdf

FAMILY HERITAGE

Life Insurance Company Of America

Executive Office: P.O. Box 470608
Cleveland, Ohio 44147

CANCER POLICY

THIS IS A LIMITED POLICY- PLEASE READ IT CAREFULLY

POLICY INDEX

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THIS POLICY HAS A 30-DAY WAITING PERIOD. NO BENEFITS ARE PAYABLE FOR CANCER DIAGNOSED WITHIN 30 DAYS AFTER THE EFFECTIVE DATE. If You are diagnosed with Cancer before the end of the Waiting Period, We will void the policy from the beginning and You will receive a full refund of Premium.

This policy is a legal contract between the Policyowner and Family Heritage Life Insurance Company of America. We agree to insure You against loss from Cancer (as defined) in return for Your Premium payments.

TEN DAY RIGHT TO EXAMINE POLICY: If, for any reason, You are not satisfied with this policy, You can return it to an authorized agent of the Company or to Our Executive Office within 10 days after You receive it for a complete refund of Premium and cancellation of the policy.

IT IS IMPORTANT that You read Your entire policy, including the application, and write to Us within 10 days if any information shown in the application is incorrect or incomplete.

GUARANTEED RENEWABILITY: This policy is continuously renewed during the Policyowner's lifetime by the payment of Premiums when due. We reserve the right to change Premium rates upon 60 days prior written notice. Such changes may only be made for all policies of this kind issued in the same state. You cannot be singled out for a rate change.

This policy is signed on behalf of FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA by its Secretary and President.

Edward J. Bucheck

Secretary

Howard L Lewis

President

SECTION 1: DEFINITIONS

When the terms below are used in this policy, the following definitions apply:

CANCER: Means a disease which manifests itself by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of body tissues by such malignant cells, leukemia or Hodgkin's Disease. Cancer also includes carcinoma in situ.

Cancer does not include premalignant conditions, conditions with malignant potential or pre-leukemic conditions.

CHEMOTHERAPY: Means U.S Food and Drug Administration (FDA) approved drugs for the destruction of malignant cells, including FDA approved targeted and experimental therapies. Chemotherapy does not include hormone treatments, immunotherapy, or other drugs which do not destroy malignant cells.

CHILD, CHILDREN: Means the Policyowner's natural children, step-children, legally adopted children, children placed with You for adoption, children petitioned for adoption or children for whom the Policyowner has permanent legal custody. Each Child must be insurable, unmarried, dependent on the Policyowner or the Policyowner's Spouse for a majority of the Child's support, and younger than age 25. A Child will be considered dependent if he or she qualifies as a legal dependent of the Policyowner or Spouse for tax exemption purposes under the U.S. Internal Revenue Service (IRS) Tax Code. The insurance on any Child will terminate at 12:00 noon (Eastern Standard Time) on the Child's 25th birthday, the date of the Child's marriage or when the Child no longer qualifies as a legal dependent for tax exemption purposes, whichever occurs first. Terminations will not affect previously incurred claims (for continuation of coverage, see SECTION 5: GENERAL PROVISIONS – CONVERSION).

Adopted Children: If this is a Family Policy or Single Parent Policy, the Policyowner's adopted Children are covered from the moment of adoption, and Children placed with You for adoption are covered from the moment of petition or placement. No notice or additional Premium is required.

If this is an Individual or Married Couple Policy, coverage shall begin on the date of the filing of a petition for adoption if coverage is applied for within 60 days after the filing of the petition for adoption. Newborn Children are covered from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the Child's birth and You pay the additional premium to continue coverage beyond 60 days.

Handicapped Children: If this is a Family Policy or Single Parent Policy, Children also includes dependent Children, regardless of age, who are mentally or physically handicapped, and became or become handicapped prior to age 25, and cannot support themselves because of their handicap. Proof of continued handicap and dependency must be provided upon Our request, but not more often than annually, after two years following the Child's 25th birthday.

Newborn Children: If this is a Family Policy or Single Parent Policy, the Policyowner's newborn Children are covered from the moment of live birth, and no notice or additional Premium is required.

If this is an Individual Policy or Married Couple Policy, the Policyowner's newborn Children are covered from the moment of live birth for the next 31 days. We must be notified within 31 days after the date of birth and receive payment of the required Premium in order to have coverage continue beyond the 31 day period.

CLAIMS INCURRED: A claim for benefits under Your policy or rider is considered incurred on the date the event or service occurs for which We pay benefits.

COVERED CANCER TREATMENT: Means definitive Cancer treatment for which benefits are payable under this policy.

DESTINATION: Means a Hospital or a Comprehensive or Clinical Cancer Center recognized by the National Cancer Institute.

DOCTOR, PHYSICIAN: Means a person, other than You or a member of Your family, who is licensed by the state to practice a healing art and performs services which are allowed by his or her license.

HOSPICE: Means an organization that provides care for the terminally ill mainly in the home, is licensed by a governmental agency, is accredited by the Joint Commission on Accreditation of Hospitals or is qualified to receive

benefit payments from Medicare or Medicaid. The organization must have on its staff at least one Doctor and one registered nurse and must keep complete medical records for each patient.

HOSPITAL: Means a medical facility, located in the United States, that is legally licensed and operated as an acute-care hospital, provides overnight care of injured and sick people, is supervised by a Doctor, provides 24-hour-a-day nursing services by or under the supervision of a registered professional nurse, and provides on-site or prearranged use of x-ray equipment, laboratory facilities and surgical units, and maintains permanent medical history records.

A Hospital is not a bed, unit or facility that functions as a nursing home, hospice, skilled nursing facility, extended care facility, convalescent home, a place for rehabilitation, rest home or a home for the aged, a place for the treatment of substance abuse, a sanatorium or a mental institution.

HOSPITALIZATION, HOSPITALIZED: Means the period of time that You are admitted as an inpatient to a Hospital and subsequently discharged. When benefits are paid for a period of time and You are readmitted within 30 days of that Hospitalization for the same diagnosis, the later Hospitalization will be treated as a continuation of the prior Hospitalization. If more than 30 days have passed between Hospitalizations, We will treat each period as a new Hospitalization.

PATHOLOGIST: Means a Doctor licensed to practice medicine and certified by the American Board of Pathology or the American Osteopathic College of Pathologists to practice pathological anatomy.

POLICY ANNIVERSARY DATE: Means the yearly recurrence of the Effective Date shown on the Policy Schedule.

POLICYOWNER: Means the person named in the Policy Schedule as the Policyowner.

PREMIUM: Means the amount of money You pay Us in return for the insurance provided by this policy and any rider(s).

RETURN OF PREMIUM MATURITY DATE: Means either the 20th Policy Anniversary Date or the date when We receive 20 full years of Premium, whichever is later.

SKIN CANCER: Means melanoma, basal cell carcinoma or squamous cell carcinoma of the skin.

SPOUSE: Means the insurable person named as Spouse on the Policy Schedule and married to the Policyowner as evidenced by a government issued license.

WE, US, OUR, COMPANY: Means Family Heritage Life Insurance Company of America.

WEEK: Means the seven day period beginning on a Sunday at 12:01 AM local time.

YOU, YOUR: If this is an Individual Policy, You means only the Policyowner. If this is a Family Policy, You means the Policyowner and the Policyowner's Spouse and Children. If this is a Single Parent Policy, You means the Policyowner and the Policyowner's Children. If this is a Married Couple Policy, You means the Policyowner and the Policyowner's Spouse.

The Policyowner may be able to add coverage for a Spouse and/or Child(ren) to this policy after the Effective Date. To do so, We must receive an application for the person along with evidence satisfactory to Us that the person is eligible and insurable. If the application is approved, We will notify the Policyowner of the date the added person's coverage becomes effective. A Spouse and/or Child(ren) added to this policy after the Effective Date will not be covered until 30 days after the application for their coverage has been approved by Us. We retain the discretion whether to allow You to add coverage for a Spouse or Child(ren) to this policy.

SECTION 2: ELIGIBILITY FOR BENEFITS

DIAGNOSIS: To be eligible for Cancer benefits under this policy, Your Cancer must be positively diagnosed in one of the following ways:

Pathological Diagnosis
A pathological diagnosis of Cancer is made from the results of a microscopic study of fixed tissue or blood samples.

This type of diagnosis must be made by a Pathologist. The Pathologist shall base judgment solely on the criteria of malignancy in keeping with the standards adopted by the American Board of Pathology or the American Osteopathic College of Pathologists. A pathological diagnosis of Cancer can be made before or after death.

Clinical Diagnosis
A Clinical Diagnosis of Cancer is based on the study of symptoms. We accept a Clinical Diagnosis only when a Pathological Diagnosis is detrimental to Your health, there is medical evidence to support the diagnosis and a Doctor is treating You for Cancer.

Other Diagnoses
We accept the pathological interpretation of the histology of skin lesions from dermatologists certified in Dermatopathology by the American Board of Dermatology.

ELIGIBILITY: You will be eligible for Cancer benefits under this policy if:

- You have never had any Cancer diagnosed prior to 30 days after You become insured under this policy unless We have specifically waived or amended this requirement in an attached amendment or rider;
- Your Cancer is diagnosed while You are insured by this policy;
- You incur a covered loss due to Your Cancer while You are insured by this policy; and
- the loss is not excluded by name or specific description in this policy.

The date of diagnosis is the earlier of the date of Clinical Diagnosis or the date the specimen used to diagnose Cancer is taken. If Cancer is first diagnosed while You are Hospitalized, You will be eligible for benefits retroactively, beginning with the date You were admitted to the Hospital, but not more than 30 days prior to the date of diagnosis. You will not be eligible for benefits for Hospitalizations which begin prior to the date You become insured under this policy.

EXCEPTION: If Skin Cancer is diagnosed while You are Hospitalized, You will be eligible for benefits only for the day(s) You actually received treatment for Skin Cancer.

While Your policy is in force, if Cancer is first diagnosed after You die, You will be eligible for benefits beginning on the date of admission for a period of continuous Hospitalization ending in Your death, but not for more than 30 days prior to the date of Your death.

Once treated for a diagnosed Cancer, You will no longer be eligible for Cancer benefits after the earlier of:

- the date that a Physician determines that there is no evidence of malignant cells, leukemia or Hodgkin's Disease, or
- five years following Your most recent diagnosis of Cancer. If five years have elapsed since Your most recent diagnosis of Cancer, You will continue to be eligible for Cancer benefits upon submission to the Company of a subsequent Pathological or Clinical Diagnosis of Cancer.

SECTION 3: BENEFITS

OUR PROMISE TO PAY: Subject to the terms, conditions, limitations and exclusions of this policy, We will pay the benefits described below. For benefits based on “charges up to” (the Anti-Nausea, Second Surgical Opinion, Prosthesis, Self-Administered Chemotherapy and Special Treatment benefits) if You do not receive a charge for Your treatment in a U.S. Government Hospital or any other medical facility, the benefit will not be paid.

FIRST OCCURRENCE – INTERNAL CANCER BENEFIT: We will pay **[$1,000/$2,000/$3,000]** when You are diagnosed for the first time, while insured under this policy, as having any internal Cancer. We will not pay this benefit for Skin Cancer. We will pay this benefit even when Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

FIRST OCCURRENCE – SKIN CANCER BENEFIT: We will pay **[$300/$600/$900]** when You are diagnosed for the first time, while insured under this policy, as having Skin Cancer. We will pay this benefit even when Skin Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

BREAST CANCER BENEFIT: We will pay **[$500/$1,000/$1,500]** when You are diagnosed for the first time, while insured under this policy, as having internal breast Cancer. We will not pay this benefit for Skin Cancer. We will

pay this benefit even when breast Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

PROSTATE CANCER BENEFIT: We will pay **[$500/$1,000/$1,500]** when You are diagnosed for the first time, while insured under this policy, as having prostate Cancer. We will pay this benefit even when prostate Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

HOSPITALIZATION BENEFIT: We will pay **[$150/$300/$450]** for each day You are Hospitalized for Covered Cancer Treatment. The benefit will be calculated based on the number of days the Hospital charges You for room and board.

AMBULANCE BENEFIT: We will pay charges up to **[$200/$400/$600]** per one-way trip if a licensed surface or air ambulance service transports You to or from a Hospital where You are Hospitalized for Covered Cancer Treatment.

This benefit is limited to two one-way trips per Hospitalization.

RADIATION PLANNING BENEFIT: We will pay **[$100/$200/$300]** per day, up to a lifetime maximum of **[$300/$600/$900]**, for Your:

- radiation planning,
- dosimetry,
- simulation,
- design and construction of devices used for Your radiation treatment, and
- continuing physics.

We will determine whether this benefit is payable based on the Current Procedural Terminology (CPT) Code shown on Your bill.

RADIATION AND CHEMOTHERAPY BENEFIT: We will pay **[$100/$200/$300]** for each day that You receive one of the following:

- radiation treatments, or
- Chemotherapy delivered either intravenously, by injection, or by infusion, and delivered by a medical professional in a medical facility.

This benefit does not pay for diagnostic x-rays or planning procedures related to these therapy treatments. This benefit is not payable for any treatments paid under the Self-Administered Chemotherapy benefit or any of the benefits paid under the Radiation Planning Benefit.

SELF-ADMINISTERED CHEMOTHERAPY BENEFIT: In any Week that You do not receive the Radiation and Chemotherapy Benefit, We will pay charges up to **[$80/$160/$240]** per Week for Your prescriptions filled for self-administered Chemotherapy. If We pay this benefit and later find that a Radiation and Chemotherapy Benefit is payable for the same Week, We will recalculate Your benefits to pay You the higher amount payable under the Radiation and Chemotherapy Benefit. This benefit has a lifetime maximum of **[$10,000/$20,000/$30,000]**.

This benefit is not payable for any treatments paid under the Radiation and Chemotherapy Benefit.

ANTI-NAUSEA BENEFIT: We will pay charges up to **[$250/$500/$750]** per calendar year when You receive anti-nausea drugs that are prescribed by a Doctor while You are receiving radiation or Chemotherapy treatments. Oral anti-nausea medication will be limited to the cost of the prescription on the day You have the prescription filled, up to the benefit amount stated above.

SPECIAL TREATMENT BENEFIT: We will pay charges up to **[$500/$1,000/$1,500]** if You receive any of the following procedures:

- Immunotherapy;
- Stem Cell Transplant;
- Hormone Therapy;
- Autologous Bone Marrow Transplant;
- Radioimmunotherapy; and
- Photodynamic Therapy.

For treatments that are self administered, We will pay charges up to **[$500/$1,000/$1,500]** for the cost of the prescription on the day the prescription is filled.

These treatments must be approved for the treatment of Cancer by the U.S. Food and Drug Administration (FDA). The amount listed is the maximum payable per lifetime for each person insured by this policy.

SURGERY AND ANESTHESIA BENEFIT: We will pay this benefit for surgery performed by a Doctor to treat or diagnose Your Cancer. Anesthesia is not required for a surgery to be payable under this policy. We will use the Current Procedural Terminology (CPT) Code from Your bill and the Relative Value for that CPT Code shown in the 2009 Relative Values for Physicians to determine the benefit amount according to the schedule below:

Relative Value	Benefit Amount	Relative Value	Benefit Amount
0.0 – 7.9	[$100/$200/$300]	39.0 – 39.9	[$1,198/$2,396/$3,594]
8.0 – 8.9	[$110/$220/$330]	40.0 – 40.9	[$1,261/$2,522/$3,783]
9.0 – 9.9	[$127/$254/$381]	41.0 – 41.9	[$1,326/$2,652/$3,978]
10.0 – 10.9	[$145/$290/$435]	42.0 – 42.9	[$1,394/$2,788/$4,182]
11.0 – 11.9	[$163/$326/$489]	43.0 – 43.9	[$1,465/$2,930/$4,395]
12.0 – 12.9	[$183/$366/$549]	44.0 – 44.9	[$1,538/$3,076/$4,614]
13.0 – 13.9	[$203/$406/$609]	45.0 – 45.9	[$1,615/$3,230/$4,845]
14.0 – 14.9	[$225/$450/$675]	46.0 – 46.9	[$1,694/$3,388/$5,082]
15.0 – 15.9	[$247/$494/$741]	47.0 – 47.9	[$1,776/$3,552/$5,328]
16.0 – 16.9	[$270/$540/$810]	48.0 – 48.9	[$1,862/$3,724/$5,586]
17.0 – 17.9	[$295/$590/$885]	49.0 – 49.9	[$1,950/$3,900/$5,850]
18.0 – 18.9	[$321/$642/$963]	50.0 – 50.9	[$2,043/$4,086/$6,129]
19.0 – 19.9	[$348/$696/$1,044]	51.0 – 51.9	[$2,138/$4,276/$6,414]
20.0 – 20.9	[$375/$750/$1,125]	52.0 – 52.9	[$2,237/$4,474/$6,711]
21.0 – 21.9	[$404/$808/$1,212]	53.0 – 53.9	[$2,340/$4,680/$7,020]
22.0 – 22.9	[$435/$870/$1,305]	54.0 – 54.9	[$2,447/$4,894/$7,341]
23.0 – 23.9	[$466/$932/$1,398]	55.0 – 55.9	[$2,558/$5,116/$7,674]
24.0 – 24.9	[$500/$1,000/$1,500]	56.0 – 56.9	[$2,673/$5,346/$8,019]
25.0 – 25.9	[$534/$1,068/$1,602]	57.0 – 57.9	[$2,792/$5,584/$8,376]
26.0 – 26.9	[$570/$1,140/$1,710]	58.0 – 58.9	[$2,915/$5,830/$8,745]
27.0 – 27.9	[$608/$1,216/$1,824]	59.0 – 59.9	[$3,044/$6,088/$9,132]
28.0 – 28.9	[$647/$1,294/$1,941]	60.0 – 60.9	[$3,177/$6,354/$9,531]
29.0 – 29.9	[$687/$1,374/$2,061]	61.0 – 61.9	[$3,314/$6,628/$9,942]
30.0 – 30.9	[$730/$1,460/$2,190]	62.0 – 62.9	[$3,457/$6,914/$10,371]
31.0 – 31.9	[$774/$1,548/$2,322]	63.0 – 63.9	[$3,605/$7,210/$10,815]
32.0 – 32.9	[$820/$1,640/$2,460]	64.0 – 64.9	[$3,759/$7,518/$11,277]
33.0 – 33.9	[$868/$1,736/$2,604]	65.0 – 65.9	[$3,918/$7,836/$11,754]
34.0 – 34.9	[$917/$1,834/$2,751]	66.0 – 66.9	[$4,083/$8,166/$12,249]
35.0 – 35.9	[$969/$1,938/$2,907]	67.0 – 67.9	[$4,253/$8,506/$12,759]
36.0 – 36.9	[$1,023/$2,046/$3,069]	68.0 – 68.9	[$4,430/$8,860/$13,290]
37.0 – 37.9	[$1,079/$2,158/$3,237]	69.0 – 69.9	[$4,613/$9,226/$13,839]
38.0 – 38.9	[$1,137/$2,274/$3,411]	70.0 – 70.9	[$4,803/$9,606/$14,409]
		71.0 +	[$5,000/$10,000/$15,000]

We will not pay for reconstructive, diagnostic, hormone related or follow-up surgery which does not definitively diagnose or treat Cancer. EXCEPTION: We will pay for reconstructive breast surgery under the Reconstructive Breast Surgery Benefit.

If two or more surgical procedures are performed on the same day, We will pay only for one surgery, the one with the highest Relative Value. For any surgery, We will pay no less than **[$100/$200/$300]** and no more than **[$5,000/$10,000/$15,000]**.

If We do not receive a CPT code for Your surgery from Your surgeon or the Hospital where it was performed, this benefit will not be paid. If We receive a CPT code from Your surgeon or the Hospital, but it is not listed in the 2009 Relative Values for Physicians, We will substitute another reasonable method of determining the benefit amount based on a comparison of Your surgery to the surgeries that are listed in the 2009 Relative Values for Physicians.

RECONSTRUCTIVE BREAST SURGERY BENEFIT: We will pay **[$250/$500/$750]** for each breast for reconstructive breast surgery following a mastectomy. We will also pay **[$250/$500/$750]** for one reconstructive surgery on a non-diseased breast to establish symmetry with a diseased breast. This benefit has a lifetime maximum of **[$500/$1,000/$1,500]** per person.

SECOND SURGICAL OPINION BENEFIT: We will pay charges up to **[$200/$400/$600]** if any covered person receives a second surgical opinion concerning Cancer surgery for a diagnosed Cancer by a licensed Physician. The second surgical opinion must occur after diagnosis and before surgery. This benefit is limited to one second opinion per surgery.

BONE MARROW TRANSPLANT BENEFIT: We will pay **[$5,000/$10,000/$15,000]** for a human bone marrow transplant that You receive for the treatment of leukemia. This benefit includes medical expenses for the bone marrow transplant and the medical expenses for the donor. We will pay this benefit no more than once for any insured person.

A human bone marrow transplant is an allogeneic or syngeneic graft of living bone marrow from one human being to another. We will not pay this benefit for autologous bone marrow transplants (when You act as Your own donor) for the implantation of artificial or synthetic bone marrow or for Stem Cell Transplants.

BONE MARROW DONOR BENEFIT: We will pay **[$1,000/$2,000/$3,000]** if You donate Your own bone marrow to another person who is receiving treatment for Cancer. We will pay this benefit no more than once for any insured person.

PROSTHESIS BENEFIT: We will pay charges up to **[$1,000/$2,000/$3,000]** for prosthetic devices which are prescribed as a direct result of Covered Cancer Treatment. The amount listed is the maximum payable per lifetime for each person insured by this policy.

WELLNESS BENEFIT: We will pay up to a maximum of **[$50/$100/$150]** per calendar year for each insured person based on the following:

- **[$50/$100/$150]** for a colonoscopy, or completion of Tobacco Cessation as described below;
- **[$40/$80/$120]** for a flexible sigmoidoscopy, barium enema, breast ultrasound, transvaginal ultrasound, or human papillomavirus (HPV) vaccine;
- **[$30/$60/$90]** for a mammography, sputum cytology, or urine cytology;
- **[$25/$50/$75]** for a pap smear, CEA, CA 125 assay, fecal occult stool specimen or prostate specific antigen test.

The HPV benefit is payable only once during the lifetime of any insured. The Tobacco Cessation benefit is only payable for the Policyowner or covered Spouse and only once during their lifetime.

Except for Tobacco Cessation, any of the above items must be administered by a medical professional for the purpose of screening or testing for the presence of Cancer. No diagnosis of Cancer is required for this benefit to be payable. This benefit is not subject to the 30-day Waiting Period.

To receive a benefit for Tobacco Cessation, You must first notify the Company of Your intent to quit using tobacco products. We will send You the necessary forms to establish a “quit date”. Payment of the benefit will only be made after You have provided Us with a certification that You have ceased using tobacco products for six consecutive months after the established quit date.

HOSPICE BENEFIT: We will pay **[$50/$100/$150]** per day for each day You receive care provided by or through a Hospice as a direct result of Your Cancer. This benefit is limited to **[$9,000/$18,000/$27,000]** per insured person. You must be diagnosed as terminally ill, no longer be receiving Covered Cancer Treatment and be expected to live six months or less.

We will pay this amount for each day You:

- receive Hospice services in Your home;
- use the services of a Hospital on an outpatient basis under the direction of a Hospice; or,
- visit or are confined to a Hospice for treatment or services.

We will not pay this benefit for any day You are an inpatient in a Hospital.

TRANSPORTATION BENEFIT: We will pay this benefit if You must travel to a Destination that is more than 80 miles one-way from Your residence for:

- Covered Cancer Treatments prescribed by Your local Physician that are not available where You live; or
- up to 3 appointments with a Physician concerning Your Cancer diagnosis that occur before Your Covered Cancer Treatment begins.

For Your travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the Destination We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip. For Your travel by automobile We will pay **[20 cents/40 cents/60 cents]** for each mile You travel. To determine the mileage We will measure the distance traveled from where You live to the Destination by using the most direct route.

FAMILY MEMBER TRANSPORTATION BENEFIT: We will pay this benefit if You are eligible for the Transportation Benefit and a Family Member also travels to the Destination where You are Hospitalized as an inpatient for Covered Cancer Treatment. We will also pay this benefit if You are eligible for the Transportation Benefit and a Family Member also travels to the Destination for up to 3 appointments with a Physician concerning Your Cancer diagnosis that occur before Your Covered Cancer Treatment begins.

For Your Family Member's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the Destination We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip; or for travel by automobile (when the Family Member resides more than 80 miles one-way from the Destination) We will pay **[20 cents/40 cents/60 cents]** for each mile the Family Member travels. To determine the mileage We will measure the distance traveled from where the Family Member lives to the Destination by using the most direct route.

This benefit is limited to one Family Member making one round trip or two one-way trips for each time We pay the Transportation Benefit. "Family Member" means Your Spouse, parent, grandparent, grandchild, brother, sister or Child. The mileage benefit is not payable if the Family Member travels in the same automobile with You.

SECOND PARENT TRANSPORTATION BENEFIT: We will pay this benefit if You are eligible for the Family Member Transportation Benefit and a second parent also travels to the Destination under the following conditions:

- a covered Child is Hospitalized as an inpatient for Covered Cancer Treatment;
- this is a Family Policy;
- the Transportation Benefit is payable for a covered Child;
- the Family Member Transportation Benefit is payable for the other parent; and
- the Destination is more than 80 miles one-way from where the second parent lives.

For the second parent's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the Destination We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip; or for travel by automobile We will pay **[20 cents/40 cents/60 cents]** for each mile the second parent travels. To determine the mileage We will measure the distance traveled from where the second parent lives to the Destination by using the most direct route. The mileage benefit is not payable if the second parent travels in the same automobile with You.

FAMILY MEMBER LODGING BENEFIT: We will pay charges up to **[$50/$100/$150]** for a Family Member's lodging in a hotel or motel under the following conditions:

- You are Hospitalized as an inpatient for Covered Cancer Treatment; and
- Your Family Member also travels to the Destination that is 80 miles one-way from where You and Your Family Member live.

"Family Member" means Your Spouse, parent, grandparent, grandchild, brother, sister or Child. This benefit is limited to payment for one hotel or motel room for each day of Your Hospitalization, up to a maximum of 60 days for each period of Hospitalization during which the Hospitalization Benefit is payable under this policy.

RETURN OF PREMIUM BENEFIT: You will be eligible for the Return of Premium Benefit if You keep Your policy in force until the Return of Premium Maturity Date. You are not required to surrender Your policy on the Return of Premium Maturity Date to receive this benefit.

The benefit amount is equal to the Premiums paid while this policy was in force minus any Claims Incurred prior to the Return of Premium Maturity Date. Premiums paid for any rider will be included in the benefit amount only if that rider is in force on the Return of Premium Maturity Date.

If this is an Individual Policy or Single Parent Policy and the Policyowner dies while this policy is in force and prior to the Return of Premium Maturity Date, We will pay a benefit amount equal to the Premiums paid while this policy was in force, minus any Claims Incurred while this policy was in force. We will pay this benefit upon Our receipt of proof of the Policyowner's death.

If this is a Family Policy or Married Couple Policy and the Policyowner and Spouse both die while this policy is in force and prior to the Return of Premium Maturity Date, We will pay a benefit amount equal to the Premiums paid while this policy was in force, minus any Claims Incurred while this policy was in force. We will pay this benefit upon Our receipt of proof of the Policyowner and Spouse's death.

SECTION 4: LIMITATIONS AND EXCLUSIONS

CANCER TREATMENT ONLY: This policy provides benefits only for loss due to Cancer and for Your Covered Cancer Treatment which occurs more than 30 days after the Effective Date of Your policy. This includes conditions or diseases caused or aggravated by or resulting from Cancer or Cancer Treatment.

SECTION 5: GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the application, Policy Schedule, and any attached riders, amendments or endorsements constitutes the entire contract of insurance. No change to this policy is valid until approved and endorsed by one of Our Executive officers and attached to this policy. No agent has authority to change this policy or to waive any of its provisions.

CHANGE OF BENEFICIARY: The right to change of Beneficiary is reserved to the Policyowner and the Policyowner can ask Us to change the Beneficiary at any time. The consent of the Beneficiary or Beneficiaries will not be required in order to change the Beneficiary or to make any other changes in this policy. The Policyowner's request must be in writing and the change must be approved by Us. If approved, it will go into effect the day the Policyowner signs the request. The change will not have any bearing on payments made before We received the request.

TERM: This policy becomes effective at 12:00 noon (Eastern Standard Time) on the Effective Date shown on Your Policy Schedule. Each renewal term ends at 12:00 noon (Eastern Standard Time) on the date to which Your Premium is paid. Renewal dates are determined by mode of payment. Your initial mode of payment is shown on Your Policy Schedule.

PREMIUMS: The first Premium is due on the Effective Date. Each Premium after the first is due on the last day of the term for which the most recent Premium was paid and must be paid to Us at Our Executive Office.

This policy will not be in force until Your Effective Date and both Your application is approved and the first Premium is accepted by Us. If We accept subsequent Premium, this policy will continue in force until the end of the term for which the Premium is due.

The amount of the first Premium for the initial mode of payment is shown in the Policy Schedule. The amount of each Premium after the first is based on Your then current mode of payment.

UNEARNED PREMIUM: If the Policyowner dies and the policy is not continued by the covered Spouse as described under the Continuation provision, any proceeds payable to the Policyowner's estate will include Premiums paid for any period beyond the end of the policy month in which the death occurred. Unearned Premiums shall be paid in a lump sum on a date no later than 30 days after the proof of the Policyowner's death has been furnished to Us.

GRACE PERIOD: If You do not pay a Premium when it is due, You can pay it during the next 31 days. During this grace period the policy will stay in force and will terminate if You do not pay the Premium by the end of the grace period.

CANCELLATION OF INSURANCE: The Policyowner may cancel this policy at any time. The Policyowner's request must be in writing and sent to Us at Our Executive Office. Cancellation will become effective on the day We receive the request, or on a later date specified in Your request. In the event of cancellation We will promptly return the unearned portion of any Premium paid. This will be calculated using the pro-rata portion of any Premium

paid. If any claim originated prior to the effective date of cancellation, We will pay the appropriate benefits due. We cannot cancel this policy for any reason other than nonpayment of Premium.

REINSTATEMENT: If this policy terminates because You do not pay the Premium by the end of the grace period, You may be able to put Your insurance back in force.

If We or Our authorized agent accept Your Premium and do not require a reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date We receive the Premium. If We or Our authorized agent require a reinstatement application at the time We accept the Premium, We will issue You a conditional receipt for the Premium. Upon Our receipt and approval of the reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date the reinstatement application is approved. If We do not mail written notice of disapproval of the reinstatement application within 45 days of the date of the conditional receipt, then this policy will automatically be reinstated as of 12:00 noon (Eastern Standard Time) on the 45th day.

The reinstated policy will cover only loss due to Cancer which is first diagnosed more than 10 days after the reinstatement date. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium was due but not to a period of more than 60 days prior to the date of reinstatement.

If an Intensive Care Unit Rider is included in this policy, the rider will not provide benefits for Hospitalization, whether or not in an Intensive Care Unit, which begin prior to the reinstatement date.

We reserve the right to make changes to this policy before We reinstate it. Any changes will be noted on or attached to the reinstated policy. In every other way, Your rights and Our rights will be the same.

CONTINUATION: In the event of the Policyowner's death, the Spouse, if covered under the policy, shall become the Policyowner. We will need proof of the Policyowner's death (a death certificate) in order to make this change.

CONVERSION: If the Policyowner's Spouse is covered under this policy and would lose insurance because of divorce or annulment, or a covered dependent Child would lose insurance because of marriage, attainment of the limiting age or the Policyowner's death, then Your Spouse and/or Child may convert to a separate policy. A written request for conversion, along with the appropriate Premium, must be sent to Our Executive Office within 60 days after the date insurance would otherwise end. We will issue, without evidence of insurability, an equal or similar policy. The converted insurance will be limited by any exclusions which applied under this policy. Additionally, any benefit amounts paid for a person under this policy will be applied to benefit limits under that person's converted policy.

CHANGE IN COVERAGE: If You are diagnosed with Cancer within 30 days following an increase in Your coverage, We will charge Premiums and pay benefits at Your prior level of coverage.

MISSTATEMENTS OF AGE: If any age or date of birth is misstated in the application, benefit amounts will be determined based on the appropriate age at the time coverage was purchased. If, based on the correct ages, We would not have issued this policy or insured certain members of Your family under this policy, then Our only responsibility will be to refund any excess Premium paid.

TIME LIMIT ON CERTAIN DEFENSES: After Your insurance has been in force for three years, We cannot deny a claim or void the policy due to a misstatement, except a fraudulent misstatement, made by the applicant in the application.

No claim for loss incurred after three years from the date You become insured under this policy will be reduced or denied on the ground that a disease or physical condition not excluded by name or specific description existed prior to the Effective Date of Your insurance.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on the Effective Date, is in conflict with the laws of the state in which Your policy was issued, will be amended to conform to the minimum requirements of those laws.

SECTION 6: CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of a claim must be given to Us within 60 days after the start of a covered loss or as soon thereafter as reasonably possible. Notice given by or on behalf of the Policyholder or Beneficiary to Us at P.O. Box 470608, Cleveland, Ohio 44147 with information sufficient to identify the Policyholder will be deemed notice of claim to Us.

CLAIM FORMS: When We receive notice of a claim, We will send forms for filing proof of loss. If these forms are not sent within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.

PROOFS OF LOSS: Written proof of loss must be furnished to Us in English at Our Executive Office within 90 days after the loss for which You are seeking benefits. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within that time provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

One or more of the following together with Your written statement or Power of Attorney may be required as proof of loss:

- a Pathologist's report;
- an autopsy report;
- a Physician's statement;
- itemized bills for purchases or services rendered;
- Hospital, medical and Physician records;
- completed Company claim forms;
- adoption papers, birth, marriage or death certificates;
- medical and pharmaceutical receipts; and
- transportation and lodging receipts.

TIME OF PAYMENT OF CLAIMS: Benefits for any loss covered by this policy will be paid immediately upon Our receipt of due written proof of loss.

PAYMENT OF CLAIMS: Benefits will be paid directly to the Policyowner. Any benefits unpaid at the time of the Policyowner's death will be paid in the following order: to any approved assignee, to the Beneficiary or to the Policyowner's estate.

EXTENSION OF BENEFITS: Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force but the extension of benefits beyond the period the policy was in force may be predicated upon the payment of the maximum benefits.

ASSIGNMENT OF BENEFITS: We will not be bound by any assignment of benefits request or authorization form unless We have given Our prior consent.

UNPAID PREMIUM: When a claim is paid, any Premium due and unpaid may be deducted from Your claim payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have You examined as often as reasonably necessary while a claim is pending. We can require an autopsy where allowed by law. Either will be done at Our expense.

LEGAL ACTION: You cannot take legal action against Us under this policy:

- within 60 days after You have sent Us written proof of loss; or,
- more than three years from the time written proof is required to be given.

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

Executive Office
P.O. Box 470608
Cleveland, Ohio 44147

INTENSIVE CARE UNIT RIDER

RIDER EFFECTIVE DATE: If issued at the same time as the policy, the Rider Effective Date is the policy Effective Date. If issued after the policy Effective Date, the Rider Effective Date will be indicated in the Policy Schedule issued with this rider.

SECTION 1: DEFINITIONS

HIGHEST LEVEL CARE: Means the highest level of acute medical care provided by a Hospital within an Intensive Care Unit. The billing rate charged by the Hospital will be used to determine when the highest level of acute medical care is delivered.

INTENSIVE CARE UNIT (ICU): Means a specifically designated facility of the Hospital which:

- provides the Highest Level Care;
- is restricted to those patients who are critically ill or injured;
- is separate and apart from other Hospital areas;
- is permanently equipped with special life-saving equipment for the care of the critically ill or injured; and
- is listed as an Intensive Care Unit in the current edition of the American Hospital Association Guide or be eligible to be listed therein.

"Intensive Care Unit (ICU)" will also include a Coronary Care Unit (CCU), Pediatric Intensive Care Unit (PICU) or Neonatal Intensive Care Unit (NICU) when meeting the above conditions.

An Intensive Care Unit (ICU) is not:

- a step down unit;
- a sub-acute care unit;
- a progressive care unit;
- an intermediate care unit;
- a bone marrow or stem cell transplant unit;
- a private monitored room;
- an observation room or unit;
- a surgical recovery room; or
- a room, bed or ward customarily used for regular patient confinements.

STEP DOWN UNIT: A Step Down Unit is part of an Intensive Care Unit where the patient is charged less than the Highest Level Care. A Step Down Unit may also be referred to as:

- a progressive care unit;
- an intermediate care unit; or
- a sub-acute care unit.

A Step Down Unit is not:

- an emergency room;
- a special care unit;
- a bone marrow or stem cell transplant unit;
- an observation room or unit;
- a surgical recovery room; or
- a room, bed or ward customarily used for regular patient Hospitalization.

PRE-EXISTING CONDITION: Means any sickness, illness, disease, injury or condition which was diagnosed by a Physician or for which You received treatment or consulted a Physician within 12 months prior to the date You become insured under this rider.

ACCIDENT: A sudden, unexpected and unintended event, which results in bodily injury to You.

VEHICULAR ACCIDENT: Means an Accident resulting from:

- riding in or operating an automobile, bus, truck, train or commercial airplane; or
- being struck by an automobile, bus, truck, train or commercial airplane.

Vehicular Accident does not include Accidents resulting from:

- riding in or operating an all-terrain vehicle (ATV), motorcycle, tractor or other farm equipment, construction equipment, boat or other water conveyance, a private airplane or glider; or
- being struck by an all-terrain vehicle (ATV), motorcycle, tractor or other farm equipment, construction equipment, boat or other water conveyance, a private airplane or glider.

SECTION 2: BENEFITS

INTENSIVE CARE UNIT BENEFIT: We will pay the appropriate amount shown below for each day You are Hospitalized in an ICU and receive the Highest Level Care. We will pay this benefit for a maximum of 30 days in an ICU per Hospitalization.

- **[$300/$600/$900/$1,200/$1,500/$1,800]** for the Policyowner or covered Spouse age 74 or younger at the beginning of the Hospitalization.
- **[$150/$300/$450/$600/$750/$900]** for a covered Child.
- **[$150/$300/$450/$600/$750/$900]** for the Policyowner or covered Spouse age 75 or older at the beginning of the Hospitalization.

VEHICULAR ACCIDENT BENEFIT: We will pay the appropriate amount shown below in addition to the Intensive Care Unit Benefit for each day You are Hospitalized in an Intensive Care Unit and receive the Highest Level Care within 48 hours after an injury resulting from a Vehicular Accident. We will pay this benefit for a maximum of 30 days in an ICU per Hospitalization. This benefit is not payable for the Step Down Unit Benefit or for Hospitalizations in a Step Down Unit.

- **[$300/$600/$900/$1,200/$1,500/$1,800]** for the Policyowner or covered Spouse age 74 or younger at the beginning of the Hospitalization.
- **[$150/$300/$450/$600/$750/$900]** for a covered Child.
- **[$150/$300/$450/$600/$750/$900]** for the Policyowner or covered Spouse age 75 or older at the beginning of the Hospitalization.

STEP DOWN UNIT BENEFIT: We will pay the appropriate amount shown below for each day You are Hospitalized in a Step Down Unit, up to 5 days in a Step Down Unit per Hospitalization.

- **[$150/$300/$450/$600/$750/$900]** for the Policyowner or covered Spouse age 74 or younger at the beginning of the Hospitalization.
- **[$75/$150/$225/$300/$375/$450]** for a covered Child.
- **[$75/$150/$225/$300/$375/$450]** for the Policyowner or covered Spouse age 75 or older at the beginning of the Hospitalization.

SURFACE AMBULANCE BENEFIT: We will pay charges up to **[$200/$400/$600/$800/$1,000/$1,200]** per Hospitalization if a licensed surface ambulance service transports You to or from a Hospital, in which You are Hospitalized in an ICU or a Step Down Unit, and the Intensive Care Unit Benefit or the Step Down Unit Benefit is payable.

AIR AMBULANCE BENEFIT: We will pay charges up to **[$500/$1,000/$1,500/$2,000/$2,500/$3,000]** per Hospitalization if a licensed air ambulance service transports You to or from a Hospital, in which You are Hospitalized in an ICU or Step Down Unit, and the Intensive Care Unit Benefit or the Step Down Unit Benefit is payable.

ACCIDENTAL DEATH BENEFIT: We will pay the appropriate amount shown below if, while insured under this rider, You are injured in an Accident and the injury causes You to die within 180 days after the Accident irrespective of total disability. The death must result from the Accident causing the injury directly and independently of all other causes. You are not required to be admitted to an ICU or Step Down Unit to be eligible for the Accidental Death Benefit.

- **[$5,000/$10,000/$15,000/$20,000/$25,000/$30,000]** for the Policyowner or covered Spouse.
- **[$2,500/$5,000/$7,500/$10,000/$12,500/$15,000]** for a covered Child.

SECTION 3: LIMITATIONS AND EXCLUSIONS

The payment of benefits is subject to all the terms and conditions of the policy and this rider including any limitations and exclusions described in specific benefits.

CHILDREN BORN WITHIN 10 MONTHS: Children born within ten (10) months of the Rider Effective Date will not be covered for any period of ICU or Step Down Unit Hospitalization that occurs or begins during the first 30 days of that Child's life.

CONFINEMENT IN PROGRESS: Hospitalizations which begin prior to 12:00 noon (Eastern Standard Time) on the date You become insured under this rider will not be covered.

We will not pay benefits for any Accident or sickness contributed to, caused by or resulting from:

PRE-EXISTING CONDITIONS: You having any Pre-Existing Condition not otherwise excluded by name or specific description. Benefits will not be paid for losses incurred during the first year after the date You become insured under this rider which relate to a Pre-Existing Condition.

ILLEGAL OCCUPATION: You committing or attempting to commit a felony or being engaged in an illegal occupation.

INTOXICANTS AND NARCOTICS: You being intoxicated or being under the influence of any narcotic or other illegal substance, unless such narcotic or substance is taken on the advice of a Physician and according to the Physician's instructions. Having a blood alcohol level that exceeds the level permitted by the laws of the state where the Accident occurs which pertain to driving a motor vehicle will be presumptive proof of intoxication.

SUICIDE: You committing or attempting to commit suicide, regardless of mental capacity.

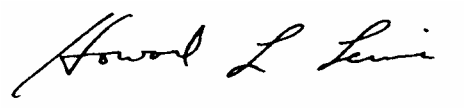
INTENTIONAL INJURIES: You intentionally injuring or attempting to injure Yourself or a covered Spouse or Child, regardless of mental capacity.

SECTION 4: GENERAL PROVISIONS

CONTRACT: This rider is part of the attached policy and will terminate when the policy terminates or when Premiums are no longer paid for this rider.

This rider is subject to all of the terms of the policy to which it is attached unless any such terms are inconsistent with the terms of this rider.

Family Heritage Life Insurance Company of America



Howard L. Lewis
President

LEAVE THIS AREA BLANK

Application To: FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
Executive Office: P.O. Box 470608, Cleveland, OH 44147

[CancerCare Plus – Series 5]

IMPORTANT: Check which person is proposed to be the Policyowner. (If no box is checked the Applicant will be the Policyowner.)

❑ Applicant's Name (Please Print: First, Middle Initial, Last)	❑ Male ❑ Female	Age	Date of Birth
❑ Husband or Wife's Name (If Family or Married Couple Coverage)	❑ Male ❑ Female	Age	Date of Birth

Applicant's Address: Number and Street City County State Zip Phone Number

Applicant's Employer's Name | Husband or Wife's Employer's Name (If Family or Married Couple Coverage)

Applicant's Employee ID (Only if needed for billing purposes)

Beneficiary's Name and Address | Relationship to Proposed Policyowner:

1. Has a medical professional EVER diagnosed or treated anyone to be covered under this policy for:

CANCER in any form? ❑ YES ❑ NO

If "YES," check (✓) the type of cancer and record name(s) of person(s) below and complete an Exclusion Rider:

A ❑ non-melanoma skin cancer. Name(s) of person(s): _____

B ❑ any melanoma cancer. Name(s) of person(s): _____

C ❑ non-melanoma internal cancer. Name(s) of person(s): _____

If "non-melanoma internal cancer," complete a Cancer Treatment History Form if applicable.

2. Has anyone to be covered under this policy:

Received an elevated PSA (Prostate-Specific Antigen) test result? ❑ YES ❑ NO

D ❑ If "YES," record name(s) of person(s) and complete an Exclusion Rider: _____

In the past 90 days been advised by a medical professional to have a biopsy for cancer that has not been performed or for which results have not been received? ❑ YES ❑ NO

E ❑ If "YES," record name(s) of person(s) and complete an Exclusion Rider: _____

3. Has a medical professional EVER diagnosed or treated anyone to be covered under this policy for:

Any heart disease; a heart condition; angina; heart attack; disorder, disease, or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; TIA (mini-stroke); or stroke? ❑ YES ❑ NO

F ❑ If "YES," record name(s) of person(s) and complete an Exclusion Rider: _____

Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ YES ❑ NO

G ❑ If "YES," record name(s) of person(s) and complete an Exclusion Rider: _____

CANCER COVERAGE		**ICU COVERAGE**		**PAYMENT**	
LEVEL	**TYPE**	**LEVEL**	**TYPE**	**MODE**	
❑ Elite ❑ Preferred ❑ Standard	❑ Individual ❑ Single Parent ❑ Married Couple ❑ Family	❑ Elite ❑ Preferred ❑ Standard [❑ _____]	❑ Individual ❑ Single Parent ❑ Married Couple ❑ Family	❑ A/C ❑ Semi-Ann ❑ Annual	Cancer $ _____ ICU $ _____ **TOTAL** $ _____

EXECUTIVE OFFICE USE Amount Collected $

Do you give Family Heritage permission to show your name for marketing purposes? ❑ YES ❑ NO

Have you ever purchased any other insurance with Family Heritage Life Insurance Co. of America? ❑ YES ❑ NO

Will this coverage replace any other accident and sickness insurance presently in force? ❑ YES ❑ NO

If "YES" please sign a Replacement Form.

[Would you like your policy delivered to you through the internet? ❑ YES ❑ NO**]**

[If "YES," please provide your e-mail address: _____ **]**

FORM C8APP-AR

APPLICATION RECEIPT

All premium checks must be made payable to the Company. Do not make check payable to the agent or leave payee blank. If you do not hear from the Company or receive your policy within 30 days, call or write to the company, giving the name of the person who signed this receipt, the type of policy applied for, the amount and the date.

Received from_____ the sum of $_____which has been tendered as payment of the first ❑ Monthly ❑ Annual ❑ Semi-Annual premium for the policy which has been applied for with Family Heritage Life Insurance Company of America. It is understood that, if issued, the policy will be in force as of the effective date shown in the policy. If the application is declined by the Company, no insurance shall be effected and the above payment will be returned to the applicant.

Date: _____ Licensed Company Representative: _____

APPLICANT'S STATEMENT: I have read, or have had read to me, the completed application. The above representations are true to the best of my knowledge and belief. I understand that: any false statements or misrepresentations in this application may result in loss of coverage; the agent has no authority to approve the application, change the policy or waive any policy provisions; and, no insurance will be effective until the date stated in my policy.

Date: _____ Signature of Applicant: _____

IMPORTANT NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

THIS SECTION TO BE COMPLETED BY AGENT: I hereby certify that I have explained to the applicant all exceptions and limitations pertaining to the coverage(s) applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being signed.

Date: _____ Signature of Agent: _____ Agent #: _____

Signed in the city of: _____ State of: _____

AUTHORIZATION FOR MONTHLY DEDUCTIONS FROM MY ACCOUNT

Draft From: ❑ Savings ❑ Checking ❑ Third Party

Account in the name of: _____
(Print Name as Shown on Bank Document)

ACH Routing #: _____ Account #: _____

Name of Bank and Branch: _____

Bank Address: _____

I hereby request and authorize you to honor and charge to my account deductions drawn on my account by and payable to Family Heritage Life Insurance Company of America (FHL), and to honor credit entries made to my account by FHL. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

This authorization shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to FHL, at the Executive Office in Cleveland, Ohio. FHL is instructed to forward authorization to you.

I request that such deductions be drawn on my account on the_____day of each month.
(Note: the 29th, 30th, and 31st are not available dates)

Date: _____ Signature of Bank Depositor: _____

To: **The Bank Named Above** So that you may comply with your depositor's request this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, deduction, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, deduction, draft or order shall be dishonored whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositor, policyowner, beneficiary or any other persons because of your actions taken pursuant to the foregoing plan of premium collection.

Howard L Lewis

President
Family Heritage Life Insurance Company of America

AGENT CHECKLIST

Review Application
- ❑ Health Questions
- ❑ Signatures
- ❑ Age Matches Birth Date
- ❑ Accuracy

Did You Collect?
- ❑ Cancer Acknowledgement
- ❑ Check
- ❑ Deposit Slip (AC only)
- ❑ Additional Forms

Follow Up Actions
- ❑ Solidify Sale
- ❑ Collect Referrals
- ❑ Field Recruit
- ❑ Ask for Pre Approach

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147 Phone Number: (440) 922-5222 Fax Number: (440) 922-5223

EXCLUSION RIDER

A ❑ Person With a History of Non-Melanoma Skin Cancer:_____ is named in the application for this policy as having been diagnosed with or treated for non-melanoma skin cancer. The Company will not be liable for any loss resulting from skin cancer for this person. Any cancer insurance for this person is limited to loss resulting from any cancer other than skin cancer.

B ❑ Person With a History of Any Melanoma Cancer:_____ is named in the application for this policy as having been diagnosed with or treated for melanoma cancer. The Company will not be liable for any loss resulting from any cancer, including skin cancer, for this person.

C ❑ Person With a History of Non-Melanoma Internal Cancer:_____ is named in the application for this policy as having been diagnosed with or treated for non-melanoma internal cancer. The Company will not be liable for any loss resulting from any cancer, including skin cancer, for this person.

This person may be eligible for insurance under this policy if, for a period of 10 consecutive years, this person has had no treatment for, diagnosis of, or recurrence of any internal cancer. This person must submit a completed Cancer Treatment History form and eligibility will be based on our review and investigation of this written statement. Any cancer insurance for this person will not be limited due to the history of non-melanoma internal cancer.

Last Date and Type of Cancer:_____

D ❑ Person With an Elevated PSA (Prostate-Specific Antigen) Test Result:_____ is named in the application for this policy as having been diagnosed with or treated for an elevated PSA test result. The Company will not be liable for any loss resulting from prostate cancer or its metastasis for this person.

E ❑ Person for Whom a Biopsy has been Recommended:_____ is named in the application for this policy as having, in the past 90 days, been advised by a medical professional to have a biopsy for cancer that has not been performed or for which results have not been received. The Company will not be liable for any loss resulting from any cancer, including skin cancer, for this person.

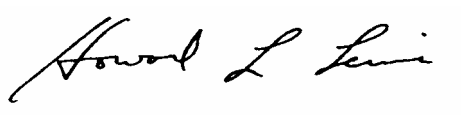
This person may be eligible for insurance under this policy if they have the recommended biopsy performed and it does not result in a diagnosis of cancer. This person must contact Customer Service to obtain the necessary form(s) to apply for removal of this exclusion. Eligibility will be based on our review and investigation of the form(s) and other documents the Company may request.

F ❑ Person With a Pre-Existing Heart Condition or Stroke (ICU Coverage):_____ is named in the application for this policy as having been diagnosed with or treated for heart disease; a heart condition; angina; heart attack; disorder, disease, or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; TIA (mini-stroke); or, stroke. For any person(s) listed above, the Company will not be liable for any loss resulting from any Intensive Care Unit Confinement contributed to or resulting from a stroke or any disorder of the heart and is limited up to seven days for any other confinement.

G ❑ Person With a History of AIDS or ARC:_____ is named in the application for this policy as having been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC). The Company will not be liable for any loss incurred by this person.

If issued at the same time as the policy, this rider will have the same Effective Date as the policy. If issued after the policy Effective Date, we will notify the Policyowner of the date this rider becomes effective. This rider is part of the policy and is subject to all of the terms of the policy to which it is attached unless any such terms are inconsistent with the terms of this rider.

Family Heritage Life Insurance Company of America



Howard L. Lewis
President

Applicant's Statement:
I have read, or have had read to me, the above representations and they are true to the best of my knowledge and belief. I understand the applicable exclusions.

_____
Signature of Applicant/Policyowner Date

CANCER POLICY CHANGE FORM

Policy # _____

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
P.O. BOX 470608, CLEVELAND, OH 44147

Policyowner's Name (Please Print: First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth	Age
Spouse's Name(If Family or Married Couple Coverage)	❑ Male ❑ Female	Date of Birth	Age

Policyowner's Address: Number and Street	City, State	Zip Code	Phone Number ( )
Name and Address of Beneficiary		Relationship to the Policyowner	

SECTION 1: TYPE OF CHANGE REQUESTED (Check all that apply)

❑ Reinstatement*	❑ Coverage Level Increase*	❑ Coverage Level Decrease	❑ Add Family Member(s)*	❑ Remove Family Member(s)	❑ Remove Rider

* Medical records may be required for any person(s) covered or to be covered under this policy. The company reserves the right to reject any coverage change or reinstatement based on existing or previous medical conditions.

SECTION 2: COVERAGE

Cancer		**Intensive Care Unit**		**Premium**	
Level	**Type**	**Level**	**Type**	**Mode**	**Total**
❑ Elite	❑ Individual	❑ Elite	❑ Individual	❑ A/C	Cancer $ _____
❑ Preferred	❑ Single Parent	❑ Preferred	❑ Single Parent	❑ Semi-Ann	ICU $ _____
❑ Standard	❑ Married Couple	❑ Standard	❑ Married Couple	❑ Annual	**TOTAL** $ _____
	❑ Family	[❑ _____]	❑ Family		

SECTION 3: ADDING FAMILY MEMBER(S) TO COVERAGE; INCREASING LEVEL OF COVERAGE; REINSTATEMENT

All of the following questions must be answered:

Has a medical professional EVER diagnosed or treated anyone to be covered under this policy for:

CANCER in any form? ❑ YES ❑ NO

If "YES," check (✓) the type of cancer and record name(s) of person(s) below and complete an Exclusion Rider:

A ❑ non-melanoma skin cancer. Name(s) of person(s): _____

B ❑ any melanoma cancer. Name(s) of person(s): _____

C ❑ non-melanoma internal cancer. Name(s) of person(s): _____

If "non-melanoma internal cancer," complete a Cancer Treatment History Form if applicable.

Has anyone to be covered under this policy:

Received an elevated PSA (Prostate-Specific Antigen) test result? ❑ YES ❑ NO

D ❑ If "YES," record name(s) of person(s) and complete an Exclusion Rider: _____

In the past 90 days been advised by a medical professional to have a biopsy for cancer that has not been performed or for which results have not been received? ❑ YES ❑ NO

E ❑ If "YES," record the name(s) of the person(s) below and complete an Exclusion Rider:
Name(s) of person(s): _____

Has a medical professional EVER diagnosed or treated anyone to be covered under this policy for:

Any heart disease; a heart condition; angina; heart attack; disorder, disease, or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; TIA (mini-stroke); or stroke? ❑ YES ❑ NO

F ❑ If "YES," record name(s) of person(s) and complete an Exclusion Rider: _____

Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ YES ❑ NO

G ❑ If "YES," record name(s) of person(s) and complete an Exclusion Rider: _____

Policy # _____

SECTION 4: REMOVING FAMILY MEMBER(S) FROM COVERAGE (Answer all of the following questions)

Are you requesting the removal of a family member because of the death of the Policyowner? ❑ YES ❑ NO
If YES, please provide a death certificate.
Are you requesting the removal of a family member because of divorce from the Policyowner? ❑ YES ❑ NO
If YES, please indicate the date of divorce:
After removing family members from coverage, are there any dependent children who will remain under your coverage? ❑ YES ❑ NO

SECTION 5: FAMILY MEMBERS (List the name, relationship and birth date of all family members who will remain on this policy.)

Name	Relationship (child, spouse)	Date of Birth	Remove/Add

IMPORTANT NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SECTION 6: APPLICANT'S STATEMENT

I have read, or have had read to me, the completed application. The above representations are true to the best of my knowledge and belief. I understand that:

For all changes:
- Any false statements or misrepresentations in the application may result in loss of coverage;
- The agent has no authority to approve the application, change the policy or waive any of its policy provisions; and,
- The Company will notify me of any adjustment in premium.

For additions and changes in coverage:
- If I am adding a family member to my coverage, the family member will not be covered until this application is approved by the Company, I have paid the appropriate premium, and the family member has satisfied the waiting period, if any;
- My existing coverage will remain in effect until the Company issues a change in coverage and its Effective Date;
- If anyone to be covered under the policy is diagnosed with cancer within 30 days following the Effective Date of an increase in coverage, the increase will be voided and my coverage and premium will return to the previous levels; and,
- Cash value surrender benefits (if any) will be based on the age of the original policyowner.

For reinstatements:
- Unless the Company disapproves this application, the coverage will be reinstated either as of the date that this application is approved, or on the 45th day following the date of the conditional receipt of my premium payment; and,
- The reinstated coverage will cover loss that results from a covered disease, if any, which is first diagnosed more than 10 days after the reinstatement date and for Intensive Care Unit coverage, hospitalizations which begin after the reinstatement date.

AUTHORIZATION: I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish any information with respect to any illness or accident, medical history or medical records to Family Heritage Life Insurance Company of America (FHL) or its representative to review for underwriting purposes. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to FHL. If I do revoke this authorization, it will not have any affect on any information released before FHL's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I or my authorized representative may request to see and copy the information described in this Authorization and that I am entitled to a signed copy of this Authorization. I acknowledge that unless an earlier date is specified under applicable law, this Authorization will expire 90 days from the date signed.

Date: _____ Signature of Applicant: _____

Policy # _____

EXCLUSION RIDER

A ❑ Person With a History of Non-Melanoma Skin Cancer:_____ is named in the application for this policy as having been diagnosed with or treated for non-melanoma skin cancer. The Company will not be liable for any loss resulting from skin cancer for this person. Any cancer insurance for this person is limited to loss resulting from any cancer other than skin cancer.

B ❑ Person With a History of Any Melanoma Cancer:_____ is named in the application for this policy as having been diagnosed with or treated for melanoma cancer. The Company will not be liable for any loss resulting from any cancer, including skin cancer, for this person.

C ❑ Person With a History of Non-Melanoma Internal Cancer:_____ is named in the application for this policy as having been diagnosed with or treated for non-melanoma internal cancer. The Company will not be liable for any loss resulting from any cancer, including skin cancer, for this person.

This person may be eligible for insurance under this policy if, for a period of 10 consecutive years, this person has had no treatment for, diagnosis of, or recurrence of any internal cancer. This person must submit a completed Cancer Treatment History form and eligibility will be based on our review and investigation of this written statement. Any cancer insurance for this person will not be limited due to the history of non-melanoma internal cancer.

Last Date and Type of Cancer:_____

D ❑ Person With an Elevated PSA (Prostate-Specific Antigen) Test Result:_____ is named in the application for this policy as having been diagnosed with or treated for an elevated PSA test result. The Company will not be liable for any loss resulting from prostate cancer or its metastasis for this person.

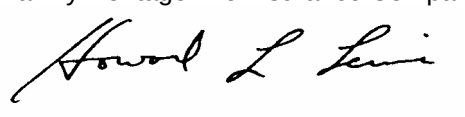
E ❑ Person for Whom a Biopsy has been Recommended:_____ is named in the application for this policy as having, in the past 90 days, been advised by a medical professional to have a biopsy for cancer that has not been performed or for which results have not been received. The Company will not be liable for any loss resulting from any cancer, including skin cancer, for this person.

This person may be eligible for insurance under this policy if they have the recommended biopsy performed and it does not result in a diagnosis of cancer. This person must contact Customer Service to obtain the necessary form(s) to apply for removal of this exclusion. Eligibility will be based on our review and investigation of the form(s) and other documents the Company may request.

F ❑ Person With a Pre-Existing Heart Condition or Stroke (ICU Coverage):_____ is named in the application for this policy as having been diagnosed with or treated for heart disease; a heart condition; angina; heart attack; disorder, disease, or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; TIA (mini-stroke); or, stroke. For any person(s) listed above, the Company will not be liable for any loss resulting from any Intensive Care Unit Confinement contributed to or resulting from a stroke or any disorder of the heart and is limited up to seven days for any other confinement.

G ❑ Person With a History of AIDS or ARC:_____ is named in the application for this policy as having been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC). The Company will not be liable for any loss incurred by this person.

If issued at the same time as the policy, this rider will have the same Effective Date as the policy. If issued after the policy Effective Date, we will notify the Policyowner of the date this rider becomes effective. This rider is part of the policy and is subject to all of the terms of the policy to which it is attached unless any such terms are inconsistent with the terms of this rider.
Family Heritage Life Insurance Company of America



Howard L. Lewis
President

Applicant's Statement: I have read, or have had read to me, the above representations and they are true to the best of my knowledge and belief. I understand the applicable exclusions.

Date: _____ Signature of Applicant: _____

FORM C8CHG-ST2

Policy # _____

AUTHORIZATION FOR MONTHLY DEDUCTIONS FROM MY ACCOUNT

DRAFT FROM: ❑ Savings ❑ Checking ❑ Third Party

ACCOUNT IN THE NAME OF: _____
(Print Name as Shown on Bank Document)

NAME OF BANK AND BRANCH: _____

STREET : _____

CITY : _____ STATE: _____

ACH ROUTING #: _____ **ACCOUNT #:** _____

I hereby request and authorize you to honor and charge to my account deductions drawn on my account by and payable to Family Heritage Life Insurance Company of America (FHL), and to honor credit entries made to my account by FHL. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

This authorization shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to Family Heritage Life Insurance Company of America, at the Executive Office in Cleveland, Ohio. Family Heritage is instructed to forward authorization to you.

I request that such deductions be drawn on my account on the_____day of each month.
(Note: the 29th, 30th, and 31st are not available dates)

Date: _____ Signature of Bank Depositor: _____

To: **The Bank Named Above**

So that you may comply with your depositor's request this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, deduction, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, deduction, draft or order shall be dishonored whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositor, policyowner, beneficiary or any other persons because of your actions taken pursuant to the foregoing plan of premium collection.

Howard L Lewis

President
Family Heritage Life Insurance Company of America

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

Executive Office: P.O. Box 470608, Cleveland, Ohio 44147

SPECIFIED DISEASE COVERAGE – CANCER ONLY

THIS POLICY PROVIDES LIMITED BENEFITS.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE

Policy Form Series C8POLRAR

This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

PLEASE READ YOUR OUTLINE OF COVERAGE CAREFULLY

This outline of coverage provides a very brief description of the important features of your coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

SPECIFIED DISEASE – CANCER ONLY COVERAGE

Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

DESCRIPTION OF BENEFITS

FIRST OCCURRENCE – INTERNAL CANCER BENEFIT: [$1,000/$2,000/$3,000] when you are diagnosed for the first time, while insured under the policy, as having any internal cancer. This benefit is not payable for skin cancer. This benefit is payable only once for any insured person.

FIRST OCCURRENCE – SKIN CANCER BENEFIT: [$300/$600/$900] when you are diagnosed for the first time, while insured under the policy, as having skin cancer. This benefit is payable only once for any insured person.

BREAST CANCER BENEFIT: [$500/$1,000/$1,500] when you are diagnosed for the first time, while insured under the policy, as having internal breast cancer. This benefit is not payable for skin cancer. This benefit is payable only once for any insured person.

PROSTATE CANCER BENEFIT: [$500/$1,000/$1,500] when you are diagnosed for the first time, while insured under the policy, as having prostate cancer. We will pay this benefit only once for any insured person.

PLEASE RETAIN THIS FOR YOUR RECORDS

HOSPITALIZATION BENEFIT: [$150/$300/$450] for each day you are hospitalized as an inpatient for covered cancer treatment. The benefit will be calculated based on the number of days the hospital charges for room and board.

AMBULANCE BENEFIT: Charges up to **[$200/$400/$600]** per one-way trip if a licensed surface or air ambulance service transports you to or from a hospital where you are hospitalized as an inpatient for covered cancer treatment. This benefit is limited to two one-way trips per inpatient hospitalization.

RADIATION PLANNING BENEFIT: [$100/$200/$300] per day, up to a lifetime maximum of **[$300/$600/$900]**, for radiation planning, dosimetry, simulation, design and construction of devices used for radiation treatment, and continuing physics. Payment of this benefit is determined based on the Current Procedural Terminology (CPT) code shown on the patient's bill.

RADIATION AND CHEMOTHERAPY BENEFIT: [$100/$200/$300] for each day that you receive radiation treatments, or chemotherapy delivered either intravenously, by injection, or by infusion, and delivered by a medical professional in a medical facility. This benefit does not pay for diagnostic x-rays or planning procedures related to these therapy treatments. This benefit is not payable for any treatments paid under the Self-Administered Chemotherapy benefit or any of the benefits paid under the Radiation Planning Benefit.

SELF-ADMINISTERED CHEMOTHERAPY BENEFIT: In any week that you do not receive the Radiation and Chemotherapy Benefit, this benefit will pay charges up to **[$80/$160/$240]** per week for prescriptions filled for self-administered chemotherapy. If this benefit is paid and we later find that a Radiation and Chemotherapy Benefit is payable for the same week, we will recalculate these benefits to pay you the higher amount payable under the Radiation and Chemotherapy Benefit. This benefit has a lifetime maximum of **[$10,000/$20,000/$30,000]**. This benefit is not payable for any treatments paid under the Radiation and Chemotherapy Benefit.

ANTI-NAUSEA BENEFIT: Charges up to **[$250/$500/$750]** per calendar year for anti-nausea drugs that are prescribed by a doctor while you are receiving radiation or chemotherapy treatments. Oral anti-nausea medication will be limited to the cost of the prescription on the day the prescription is filled, up to the benefit amount stated above.

SPECIAL TREATMENT BENEFIT: Charges up to **[$500/$1,000/$1,500]** for Immunotherapy; Stem Cell Transplant; Hormone Therapy; Autologous Bone Marrow Transplant; Radioimmunotherapy; and Photodynamic Therapy. For treatments that are self administered, charges up to **[$500/$1,000/$1,500]** for the cost of the prescription on the day the prescription is filled. These treatments must be approved for the treatment of cancer by the U.S. Food and Drug Administration. The amount listed is the maximum payable per lifetime for each person insured by this policy.

SURGERY AND ANESTHESIA BENEFIT: This benefit is payable for surgery performed by a doctor to treat or diagnose cancer. We will use the Current Procedural Terminology (CPT) Code from the patient's bill and the Relative Value for that CPT Code shown in the 2009 Relative Values for Physicians to determine the benefit amount according to the schedule in the policy. This benefit is not payable for reconstructive, diagnostic, hormone related or follow-up surgery which does not definitively diagnose or treat cancer. EXCEPTION: Reconstructive breast surgery is payable under the Reconstructive Breast Surgery Benefit.

If two or more surgical procedures are performed on the same day, only one surgery will be payable, the one with the highest Relative Value. For any surgery, we will pay no less than **[$100/$200/$300]** and no more than the **[$5,000/$10,000/$15,000]**.

If we do not receive a CPT code for your surgery from the surgeon or the hospital where it was performed, this benefit will not be paid. If we receive a CPT code from the surgeon or the hospital, but it is not listed in the 2009 Relative Values for Physicians, we will substitute another reasonable method of determining the benefit amount based on a comparison of the surgery to the surgeries that are listed in the 2009 Relative Values for Physicians.

RECONSTRUCTIVE BREAST SURGERY BENEFIT: [$250/$500/$750] for each breast for reconstructive breast surgery following a mastectomy. **[$250/$500/$750]** is also payable for one reconstructive surgery on a non-diseased breast to establish symmetry with a diseased breast. This benefit has a lifetime maximum of **[$500/$1,000/$1,500]** per person.

SECOND SURGICAL OPINION BENEFIT: Charges up to **[$200/$400/$600]** if any covered person receives a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician. The second surgical opinion must occur after diagnosis and before surgery. This benefit is limited to one second opinion per surgery.

BONE MARROW TRANSPLANT BENEFIT: [$5,000/$10,000/$15,000] for a human bone marrow transplant for the treatment of leukemia. This benefit includes medical expenses for the bone marrow transplant and the medical expenses for the donor. We will pay this benefit no more than once for any insured person. This benefit is not payable for autologous bone marrow transplants (when you act as your own donor) for the implantation of artificial or synthetic bone marrow or for stem cell transplants.

BONE MARROW DONOR BENEFIT: [$1,000/$2,000/$3,000] if you donate your own bone marrow to another person who is receiving treatment for cancer. We will pay this benefit no more than once for any insured person.

PROSTHESIS BENEFIT: Charges up to **[$1,000/$2,000/$3,000]** for prosthetic devices which are prescribed as a direct result of covered cancer treatment. The amount listed is the maximum payable per lifetime for each person insured by this policy.

WELLNESS BENEFIT: Up to a maximum of **[$50/$100/$150]** per calendar year for each insured person based on the following:

- **[$50/$100/$150]** for a colonoscopy, or completion of Tobacco Cessation as described below;
- **[$40/$80/$120]** for a flexible sigmoidoscopy, barium enema, breast ultrasound, transvaginal ultrasound, or human papillomavirus (HPV) vaccine;
- **[$30/$60/$90]** for a mammography, sputum cytology, or urine cytology;
- **[$25/$50/$75]** for a pap smear, CEA, CA 125 assay, fecal occult stool specimen or prostate specific antigen test.

The HPV benefit is payable only once during the lifetime of any insured. The Tobacco Cessation benefit is only payable for the Policyowner or covered Spouse and only once during their lifetime.

Except for Tobacco Cessation, any of the above items must be administered by a medical professional for the purpose of screening or testing for the presence of cancer. No diagnosis of cancer is required for this benefit to be payable. This benefit is not subject to the 30-day Waiting Period.

HOSPICE BENEFIT: [$50/$100/$150] per day for each day that care is provided by or through a hospice as a direct result of cancer. This benefit is limited to **[$9,000/$18,000/$27,000]** per insured person. You must be diagnosed as terminally ill, no longer be receiving covered cancer treatment and be expected to live six months or less.

This benefit will be payable for each day you receive hospice services in your home, use the services of a hospital on an outpatient basis under the direction of a hospice, or visit or are confined to a hospice for treatment or services. We will not pay this benefit for any day you are an inpatient in a hospital.

TRANSPORTATION BENEFIT: This benefit is payable for travel to a hospital or a comprehensive or clinical cancer center that is more than 80 miles one-way from your residence for covered cancer treatments prescribed by a local physician that are not available where you live; or up to 3 appointments with a physician concerning your cancer diagnosis that occur before your covered cancer treatment begins.

For travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the hospital or cancer center this benefit pays charges up to **[$1,000/$2,000/$3,000]** per round trip. For travel by automobile this benefit pays **[20 cents/40 cents/60 cents]** for each mile traveled.

FAMILY MEMBER TRANSPORTATION BENEFIT: This benefit is payable if you are eligible for the Transportation Benefit and a family member also travels to the hospital or cancer center where you are hospitalized as an inpatient for covered cancer treatment. "Family member" means your spouse, parent, grandparent, grandchild, brother, sister or child. We will also pay this benefit if you are eligible for the Transportation Benefit and a family member also travels to the hospital or cancer center for up to 3 appointments with a physician concerning your cancer diagnosis that occur before covered cancer treatment begins.

This benefit pays charges up to **[$1,000/$2,000/$3,000]** per round trip for a family member's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the hospital or cancer center. Or, for travel by automobile (when the family member resides more than 80 miles one-way from the hospital or cancer center) this benefit pays **[20 cents/40 cents/60 cents]** for each mile the family member travels.

This benefit is limited to one family member making one round trip or two one-way trips for each time the Transportation Benefit is paid. The mileage benefit is not payable if the family member travels in the same automobile with the patient.

SECOND PARENT TRANSPORTATION BENEFIT: This benefit is payable if you are eligible for the Family Member Transportation Benefit and a second parent also travels to the hospital or cancer center under the following conditions:

- a covered child is hospitalized as an inpatient for covered cancer treatment;
- this is a family policy;
- the Transportation Benefit is payable for a covered child;
- the Family Member Transportation Benefit is payable for the other parent; and
- the hospital or cancer center is more than 80 miles one-way from where the second parent lives.

For the second parent's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the hospital or cancer center this benefit pays charges up to **[$1,000/$2,000/$3,000]** per round trip. Or, for travel by automobile this benefit pays **[20 cents/40**

cents/60 cents] for each mile the second parent travels. The mileage benefit is not payable if the second parent travels in the same automobile with the patient.

FAMILY MEMBER LODGING BENEFIT: This benefit pays charges up to **[$50/$100/$150]** for a family member's lodging in a hotel or motel under the following conditions:

- you are hospitalized as an inpatient for covered cancer treatment; and
- your family member also travels to the hospital or cancer center that is 80 miles one-way from where you and your family member live.

This benefit is limited to payment for one hotel or motel room for each day of hospitalization, up to a maximum of 60 days for each period of hospitalization during which the Hospitalization Benefit is payable under this policy.

RETURN OF PREMIUM BENEFIT: This benefit is payable if the policy is kept in force until the Return of Premium Maturity Date (either the 20th Policy Anniversary Date or the date when we receive 20 full years of premium, whichever is later). The benefit amount is equal to the premiums paid while this policy was in force minus any claims incurred prior to the Return of Premium Maturity Date. Premiums paid for any rider will be included in the benefit amount only if that rider is in force on the Return of Premium Maturity Date.

If this is an Individual Policy or Single Parent Policy and the Policyowner dies while this policy is in force and prior to the Return of Premium Maturity Date, we will pay a benefit amount equal to the premiums paid while this policy was in force, minus any claims incurred while this policy was in force. We will pay this benefit upon our receipt of proof of the Policyowner's death.

If this is a Family Policy or Married Couple Policy and the Policyowner and Spouse both die while this policy is in force and prior to the Return of Premium Maturity Date, we will pay a benefit amount equal to the premiums paid while this policy was in force, minus any claims Incurred while this policy was in force. We will pay this benefit upon our receipt of proof of the Policyowner and Spouse's death.

LIMITATIONS AND EXCLUSIONS

This policy provides benefits only for loss due to cancer and for your covered cancer treatment which occurs more than 30 days after the effective date of your policy. This includes conditions or diseases caused or aggravated by or resulting from Cancer or Cancer Treatment.

RENEWABILITY

This policy is renewable for life. Rates may be changed only if changed on all policies of this kind in your state.

COVERAGE

Benefit dollar amounts are stated throughout this Outline of Coverage in the following order from left to right: **Standard Level/Preferred Level/Elite Level.**

You have applied for the ☐ **Standard** ☐ **Preferred** ☐ **Elite** benefit level.

PLEASE RETAIN THIS FOR YOUR RECORDS

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147, (440) 922-5151

CANCER AND ICU CLAIM FORM

Instructions: 1. Have the claimant answer all questions, sign and date SIDE 1.
2. Have the treating physician complete SIDE 2.

If filing a **cancer claim** submit one claim form for each hospital admission along with all itemized hospital bills, doctor bills, surgery bills from the surgeon with an attached pathology report, and chemotherapy/radiation bills.

If filing an **intensive care claim** submit one claim form for each hospital admission along with a copy of the itemized hospital bill listing the intensive care charges and an ambulance bill, if applicable.

1. Policyowner's Name: _____ 2. Policy #: _____

3. Claimant's Name: _____ 4. Social Security No.: _____

5. Address: _____ 6. Phone number: ( ) _____

_____ 7. Date of Birth: _____

8. Relationship to Policyowner: _____ 9. Describe illness/injury: _____

10. Date first consulted physician: _____ 11. Date diagnosed: _____

12. Have you ever had this condition before? ❑ YES ❑ NO If YES, when? _____

13. List all treating physicians. Include name and phone number:

_____

_____

14. Name and phone number of family physician:

_____

_____

15. Name and phone number of other physicians:

_____

_____

16. If hospitalized, when? From _____ to _____ Hospital phone: ( ) _____

17. Hospital name: _____
city state

18. Have you ever filed a claim for this condition with Family Heritage? ❑ YES ❑ NO

IMPORTANT NOTICE: Any person who, knowingly facilitates a fraud or has intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

AUTHORIZATION MUST BE SIGNED BEFORE CLAIM CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish to Family Heritage Life Insurance Company of America or its representative or permit said insurance company or its representative to review for underwriting purposes any information with respect to any illness or accident, medical history or medical records. I understand that a photostatic copy of this authorization shall be considered as valid as the original and shall remain valid for 30 months from the date signed. I further understand that I or my authorized representative may request a copy of this authorization.

Signed _____ Date _____
Claimant, Parent (If Child) or Executor

IF THE CLAIMANT IS UNABLE TO PROVIDE A SIGNATURE, PLEASE INCLUDE A COPY OF A POWER OF ATTORNEY, LETTER OF EXECUTOR AND/OR DEATH CERTIFICATE

SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

Cancer Claims:

1. When was **any** type of cancer first diagnosed? _____ Diagnosis code(s): _____

2. When did you first consult the most recent condition? _____

3. Is this a recurrence of a previous cancer? ❑ YES ❑ NO If YES, give date of recurrence: _____

List date of last known cancer treatment: _____ Type of treatment: _____

4. List name of referring physician: _____ Phone number: _____

5. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

If YES, list name & address of facility: _____

Date admitted: _____ Date discharged: _____

6. If outpatient, list dates of service: _____

7. What services were rendered during the period listed above?
_____ biopsy _____ surgery _____ chemotherapy _____ radiation _____ hospice _____ skilled nursing

8. Please provide any applicable procedure code(s): _____

_____

9. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Intensive Care Claims:

1. Has the patient **ever** been diagnosed with or treated for a heart attack, heart disease or stroke? ❑ YES ❑ NO

2. Date of first diagnosis: _____ 3. Date of first treatment: _____

4. List reason for hospitalization: _____

5. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO

If YES, when? _____

6. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

If YES, list name & address of facility: _____

Date admitted: _____ Date discharged: _____

7. List specific dates of intensive care confinement: _____

8. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Physician's Information:

Physician's Name: _____

Specialty: _____

Address and phone number: _____

Completed by (please print): _____ Position/Title: _____

Physician's Signature: _____ **Date:** _____

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147
Phone Number: (440) 922-5222 Fax Number: (440) 922-5223

EXECUTIVE OFFICE USE: **Underwriter:** _____ **Policy Number:** _____

UNDERWRITING INFORMATION RELEASE

In the application for coverage, you were named as possibly:

- ❑ being diagnosed with or treated for cancer;
- ❑ receiving an elevated PSA (Prostate-Specific Antigen) test result;
- ❑ having been advised to have a biopsy for cancer that had either not been performed, or had been performed but the results had not been received; or
- ❑ being diagnosed with or treated for heart disease, a heart condition, or a stroke.

Please complete Section I. This form will be submitted by the Home Office to the physician(s) below in order to establish if coverage can be provided. The physician(s) must have medical information regarding the condition described.

Section I: APPLICANT'S STATEMENT

1) Name of Patient: _____

2) Patient's Social Security No.: _____ 3) Patient's Date of Birth: _____

4) Name(s) of treating Physician(s): _____

5) Physician(s) Information

Name: _____ Phone No.: ( ) _____

Address: _____

Name: _____ Phone No.: ( ) _____

Address: _____

6) Please describe the questionable medical condition in detail: _____

_____

7) List last known date of diagnosis or treatment regarding the above condition: _____
(month/year)

AUTHORIZATION MUST BE SIGNED BEFORE APPLICATION CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish to Family Heritage Life Insurance Company of America or its representative or permit said insurance company or its representative to review for underwriting purposes any information with respect to any illness or accident, medical history or medical records. I understand that a photostatic copy of this authorization shall be considered as valid as the original and shall remain valid for 30 months from the date signed. I further understand that I or my authorized representative may request a copy of this authorization.

Signed _____ **Date** _____
Patient (or Parent, if Child)

Section II: PHYSICIAN STATEMENT (please complete this section regarding the named patient)

1) Please describe the patient's cancer / PSA results / biopsy results / heart condition / stroke in detail: _____

_____

_____

_____

2) If condition is for cancer, is the patient taking any hormone therapy or chemotherapy drugs? ❑ YES ❑ NO

If YES, list name of drugs: _____

3) Since making an application for coverage, has the patient had a biopsy for cancer? ❑ YES ❑ NO

If YES, what were the results? _____

_____

4) When was the patient **first** treated or diagnosed with the condition listed? _____

5) When was the patient **last** treated or diagnosed with the condition listed? _____

6) When was the patient first and last seen by you? _____ _____

7) List the name and phone number for the referring physician: _____

_____ ( ) -

Physician's Signature _____ **Date** _____

FAMILY HERITAGE®
Life Insurance Company Of America

FOR ALL APPLICANTS

ACKNOWLEDGEMENT OF SUPPLEMENTAL COVERAGE

I acknowledge that the Family Heritage policy I am applying for:

- is not a major medical plan;
- supplements my existing insurance coverage;
- should not be viewed as a replacement for any insurance I may own; and
- provides benefits for (check all that apply):

_____ accidental injury

_____ cancer

_____ intensive care unit confinement

_____ heart attack, stroke and heart disease

X _____
Applicant Date

X _____
Representative Date

NOTICE: If you or any insurable family members are Medicaid or state-assisted government program recipients at the time of a claim, then the benefits paid directly to you will be severely limited. In these instances, most of the benefits are required to be paid to Medicaid or the other state-assisted programs or your health care provider.

Thank you for choosing Family Heritage for your supplemental insurance needs. It is our pleasure serving you.

FAMILY HERITAGE®
Life Insurance Company Of America

FOR APPLICANTS 65 & OLDER

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare generally pays for most or all of these expenses.

Medicare generally pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide* to *Health Insurance for People with Medicare,* available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

x _____ x _____
Applicant Date Representative Date

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 09/07/2010	Cancer Policy Rate Sheet	C8POLRAR	New		Cancer Policy Rates.pdf
Approved-Closed 09/07/2010	Intensive Care Unit Rider Rate Sheet	I8RID-EAR	New		ICU Rider Rates.pdf

Family Heritage Life Insurance Company of America

NAIC Company Code 77968

Exhibit 3A - Cancer Monthly Premium Rates

	Issue Age	Individual	Couple	Single Parent	Family
Elite	0 - 30	41.00	54.00	46.00	59.00
	31 - 35	44.00	58.00	49.00	63.00
	36 - 40	47.00	66.00	52.00	71.00
	41 - 45	51.00	76.00	57.00	81.00
	46 - 50	59.00	88.00	66.00	95.00
	51 - 55	71.00	114.00	78.00	121.00
	56 - 60	99.00	140.00	108.00	149.00
	61 - 65	120.00	177.00	125.00	183.00
	66 - 70	134.00	208.00	139.00	213.00
	71 - 75	149.00	227.00	153.00	232.00
	76 +	228.00	301.00	232.00	306.00
Preferred	0 - 30	35.00	46.00	38.00	49.00
	31 - 35	37.00	48.00	40.00	51.00
	36 - 40	40.00	54.00	43.00	57.00
	41 - 45	43.00	61.00	46.00	64.00
	46 - 50	49.00	71.00	53.00	76.00
	51 - 55	58.00	90.00	62.00	95.00
	56 - 60	78.00	108.00	84.00	114.00
	61 - 65	93.00	135.00	96.00	138.00
	66 - 70	107.00	161.00	110.00	164.00
	71 - 75	118.00	172.00	121.00	175.00
	76 +	178.00	231.00	181.00	234.00
Standard	0 - 30	27.00	33.00	29.00	35.00
	31 - 35	28.00	35.00	30.00	37.00
	36 - 40	30.00	38.00	32.00	40.00
	41 - 45	31.00	42.00	33.00	44.00
	46 - 50	35.00	46.00	37.00	49.00
	51 - 55	41.00	57.00	43.00	60.00
	56 - 60	54.00	68.00	57.00	71.00
	61 - 65	59.00	80.00	61.00	82.00
	66 - 70	72.00	97.00	74.00	99.00
	71 - 75	81.00	105.00	83.00	107.00
	76 +	112.00	133.00	114.00	135.00

Bi-weekly = [(12 / 26) x Monthly] rounded to nearest penny
Quarterly = 3 x Monthly
Semiannual = 6 x Monthly
Annual = 12 x Monthly

Family Heritage Life Insurance Company of America

NAIC Company Code 77968

Exhibit 7B - ICU Monthly Premium Rates per $300 of ICU

Issue Age	Individual	Couple	Single Parent	Family
0 - 30	3.00	4.00	5.00	6.00
31 - 35	4.00	7.00	6.00	9.00
36 - 40	5.00	9.00	7.00	11.00
41 - 45	7.00	12.00	9.00	14.00
46 - 50	8.00	14.00	10.00	16.00
51 - 55	9.00	17.00	11.00	19.00
56 - 60	10.00	19.00	12.00	21.00
61 - 65	13.00	26.00	15.00	28.00

Bi-weekly = [(12 / 26) x Monthly] rounded to nearest penny
Quarterly = 3 x Monthly
Semiannual = 6 x Monthly
Annual = 12 x Monthly

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/07/2010

Comments:

The Certification for Rule & Regulation 19 is attached.
Form AR-GUAR (attached - approved by the Department on 8/6/1999) is the form issued to all Arkansas policyholders pursuant to Rule & Regulation 49.
The Flesch Readability Certification is attached.
Form AR-LTR (attached - approved by the Department on 8/6/1999) is our Consumer Information Notice and will be issued to all Arkansas policyholders.

Attachments:

AR-LTR.pdf
Ar-guar.pdf
Readability Cert.pdf
Rule & Reg 19 Cert.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	09/07/2010

Comments:

The application for this policy can be found under the Form Schedule tab.

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	09/07/2010

Comments:

An outline of coverage for this policy can be found under the Form Schedule tab.

FAMILY HERITAGE

Life Insurance Company of America

A Southwestern/Great American Company

Dear Insured,

We are here to serve you...

As our policyholder, your satisfaction is very important to us. If you have a question about your policy, if you need assistance with a problem, or if you have a claim, you should contact our Home Office at (440) 922-5222 or write to us at P.O. Box 470608, Cleveland, OH 44147. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

Should you feel you are not being treated fairly with respect to a claim, you may contact the Arkansas Department of Insurance with your complaint.

To contact the Department, write or call:

Consumer Services Division
Arkansas Insurance Department
1200 W. 3rd Street
Little Rock, AR 72201-1904
(501) 371-2640 or 1-800-852-5494

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rates yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or a similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy of contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Family Heritage Life Insurance Company of America

I hereby certify that Policy Form C8POLRAR meets the minimum reading ease score on the Flesch Reading Ease Test and that it complies with the requirements of ACA 23-80-206, cited as the Life and Accident and Health Insurance Policy Language Simplification Act.

Signature

Henry G. Grendell
Name

Vice President & General Counsel
Title

August 25, 2010
Date

FAMILY HERITAGE®
Life Insurance Company Of America

Certification of Compliance with Rule and Regulation 19

I hereby certify that this submission (Form C8POLRAR, et al) meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signature

Henry G. Grendell
Name

Vice President & General Counsel
Title

August 25, 2010
Date

P.O. Box 470608 • Cleveland, Ohio 44147

(440) 922-5200 FAX: (440) 922-5201

SERFF Tracking Number:	*FHLA-126785089*	*State:*	*Arkansas*
Filing Company:	*Family Heritage Life Insurance Company of America*	*State Tracking Number:*	*46624*
Company Tracking Number:	*C8POLRAR*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*Individual Specified Disease Policy*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/26/2010	Form	Individual Cancer Policy	09/03/2010	C8POLRAR.pdf (Superceded)
08/26/2010	Form	Outline of Coverage	09/03/2010	C8OOCRST.pdf (Superceded)

FAMILY HERITAGE

Life Insurance Company Of America

Executive Office: P.O. Box 470608
Cleveland, Ohio 44147

CANCER POLICY

THIS IS A LIMITED POLICY- PLEASE READ IT CAREFULLY

POLICY INDEX

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THIS POLICY HAS A 30-DAY WAITING PERIOD. NO BENEFITS ARE PAYABLE FOR CANCER DIAGNOSED WITHIN 30 DAYS AFTER THE EFFECTIVE DATE. If You are diagnosed with Cancer before the end of the Waiting Period, We will void the policy from the beginning and You will receive a full refund of Premium.

This policy is a legal contract between the Policyowner and Family Heritage Life Insurance Company of America. We agree to insure You against loss from Cancer (as defined) in return for Your Premium payments.

TEN DAY RIGHT TO EXAMINE POLICY: If, for any reason, You are not satisfied with this policy, You can return it to an authorized agent of the Company or to Our Executive Office within 10 days after You receive it for a complete refund of Premium and cancellation of the policy.

IT IS IMPORTANT that You read Your entire policy, including the application, and write to Us within 10 days if any information shown in the application is incorrect or incomplete.

GUARANTEED RENEWABILITY: This policy is continuously renewed during the Policyowner's lifetime by the payment of Premiums when due. We reserve the right to change Premium rates upon 60 days prior written notice. Such changes may only be made for all policies of this kind issued in the same state. You cannot be singled out for a rate change.

This policy is signed on behalf of FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA by its Secretary and President.

Edward J. Bucheck

Secretary

Howard L Lewis

President

SECTION 1: DEFINITIONS

When the terms below are used in this policy, the following definitions apply:

CANCER: Means a disease which manifests itself by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of body tissues by such malignant cells, leukemia or Hodgkin's Disease. Cancer also includes carcinoma in situ.

Cancer does not include premalignant conditions, conditions with malignant potential or pre-leukemic conditions.

CHEMOTHERAPY: Means U.S Food and Drug Administration (FDA) approved drugs for the destruction of malignant cells, including FDA approved targeted and experimental therapies. Chemotherapy does not include hormone treatments, immunotherapy, or other drugs which do not destroy malignant cells.

CHILD, CHILDREN: Means the Policyowner's natural children, step-children, legally adopted children, children placed with You for adoption, children petitioned for adoption or children for whom the Policyowner has permanent legal custody. Each Child must be insurable, unmarried, dependent on the Policyowner or the Policyowner's Spouse for a majority of the Child's support, and younger than age 25. A Child will be considered dependent if he or she qualifies as a legal dependent of the Policyowner or Spouse for tax exemption purposes under the U.S. Internal Revenue Service (IRS) Tax Code. The insurance on any Child will terminate at 12:00 noon (Eastern Standard Time) on the Child's 25th birthday, the date of the Child's marriage or when the Child no longer qualifies as a legal dependent for tax exemption purposes, whichever occurs first. Terminations will not affect previously incurred claims (for continuation of coverage, see SECTION 5: GENERAL PROVISIONS – CONVERSION).

Adopted Children: If this is a Family Policy or Single Parent Policy, the Policyowner's adopted Children are covered from the moment of adoption, and Children placed with You for adoption are covered from the moment of petition or placement. No notice or additional Premium is required.

If this is an Individual or Married Couple Policy, coverage shall begin on the date of the filing of a petition for adoption if coverage is applied for within 60 days after the filing of the petition for adoption. Newborn Children are covered from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the Child's birth and You pay the additional premium to continue coverage beyond 60 days.

Handicapped Children: If this is a Family Policy or Single Parent Policy, Children also includes dependent Children, regardless of age, who are mentally or physically handicapped, and became or become handicapped prior to age 25, and cannot support themselves because of their handicap. Proof of continued handicap and dependency must be provided upon Our request, but not more often than annually, after two years following the Child's 25th birthday.

Newborn Children: If this is a Family Policy or Single Parent Policy, the Policyowner's newborn Children are covered from the moment of live birth, and no notice or additional Premium is required.

If this is an Individual Policy or Married Couple Policy, the Policyowner's newborn Children are covered from the moment of live birth for the next 31 days. We must be notified within 31 days after the date of birth and receive payment of the required Premium in order to have coverage continue beyond the 31 day period.

CLAIMS INCURRED: A claim for benefits under Your policy or rider is considered incurred on the date the event or service occurs for which We pay benefits.

COVERED CANCER TREATMENT: Means definitive Cancer treatment for which benefits are payable under this policy.

DESTINATION: Means a Hospital or a Comprehensive or Clinical Cancer Center recognized by the National Cancer Institute.

DOCTOR, PHYSICIAN: Means a person, other than You or a member of Your family, who is licensed by the state to practice a healing art and performs services which are allowed by his or her license.

HOSPICE: Means an organization that provides care for the terminally ill mainly in the home, is licensed by a governmental agency, is accredited by the Joint Commission on Accreditation of Hospitals or is qualified to receive

benefit payments from Medicare or Medicaid. The organization must have on its staff at least one Doctor and one registered nurse and must keep complete medical records for each patient.

HOSPITAL: Means a medical facility, located in the United States, that is legally licensed and operated as an acute-care hospital, provides overnight care of injured and sick people, is supervised by a Doctor, provides 24-hour-a-day nursing services by or under the supervision of a registered professional nurse, and provides on-site or prearranged use of x-ray equipment, laboratory facilities and surgical units, and maintains permanent medical history records.

A Hospital is not a bed, unit or facility that functions as a nursing home, hospice, skilled nursing facility, extended care facility, convalescent home, a place for rehabilitation, rest home or a home for the aged, a place for the treatment of substance abuse, a sanatorium or a mental institution.

HOSPITALIZATION, HOSPITALIZED: Means the period of time that You are admitted as an inpatient to a Hospital and subsequently discharged. When benefits are paid for a period of time and You are readmitted within 30 days of that Hospitalization for the same diagnosis, the later Hospitalization will be treated as a continuation of the prior Hospitalization. If more than 30 days have passed between Hospitalizations, We will treat each period as a new Hospitalization.

PATHOLOGIST: Means a Doctor licensed to practice medicine and certified by the American Board of Pathology or the American Osteopathic College of Pathologists to practice pathological anatomy.

POLICY ANNIVERSARY DATE: Means the yearly recurrence of the Effective Date shown on the Policy Schedule.

POLICYOWNER: Means the person named in the Policy Schedule as the Policyowner.

PREMIUM: Means the amount of money You pay Us in return for the insurance provided by this policy and any rider(s).

RETURN OF PREMIUM MATURITY DATE: Means either the 20th Policy Anniversary Date or the date when We receive 20 full years of Premium, whichever is later.

SKIN CANCER: Means melanoma, basal cell carcinoma or squamous cell carcinoma of the skin.

SPOUSE: Means the insurable person named as Spouse on the Policy Schedule and married to the Policyowner as evidenced by a government issued license.

WE, US, OUR, COMPANY: Means Family Heritage Life Insurance Company of America.

WEEK: Means the seven day period beginning on a Sunday at 12:01 AM local time.

YOU, YOUR: If this is an Individual Policy, You means only the Policyowner. If this is a Family Policy, You means the Policyowner and the Policyowner's Spouse and Children. If this is a Single Parent Policy, You means the Policyowner and the Policyowner's Children. If this is a Married Couple Policy, You means the Policyowner and the Policyowner's Spouse.

The Policyowner may be able to add coverage for a Spouse and/or Child(ren) to this policy after the Effective Date. To do so, We must receive an application for the person along with evidence satisfactory to Us that the person is eligible and insurable. If the application is approved, We will notify the Policyowner of the date the added person's coverage becomes effective. A Spouse and/or Child(ren) added to this policy after the Effective Date will not be covered until 30 days after the application for their coverage has been approved by Us. We retain the discretion whether to allow You to add coverage for a Spouse or Child(ren) to this policy.

SECTION 2: ELIGIBILITY FOR BENEFITS

DIAGNOSIS: To be eligible for Cancer benefits under this policy, Your Cancer must be positively diagnosed in one of the following ways:

Pathological Diagnosis
A pathological diagnosis of Cancer is made from the results of a microscopic study of fixed tissue or blood samples.

This type of diagnosis must be made by a Pathologist. The Pathologist shall base judgment solely on the criteria of malignancy in keeping with the standards adopted by the American Board of Pathology or the American Osteopathic College of Pathologists. A pathological diagnosis of Cancer can be made before or after death.

Clinical Diagnosis
A Clinical Diagnosis of Cancer is based on the study of symptoms. We accept a Clinical Diagnosis only when a Pathological Diagnosis is detrimental to Your health, there is medical evidence to support the diagnosis and a Doctor is treating You for Cancer.

Other Diagnoses
We accept the pathological interpretation of the histology of skin lesions from dermatologists certified in Dermatopathology by the American Board of Dermatology.

ELIGIBILITY: You will be eligible for Cancer benefits under this policy if:

- You have never had any Cancer diagnosed prior to 30 days after You become insured under this policy unless We have specifically waived or amended this requirement in an attached amendment or rider;
- Your Cancer is diagnosed while You are insured by this policy;
- You incur a covered loss due to Your Cancer while You are insured by this policy; and
- the loss is not excluded by name or specific description in this policy.

The date of diagnosis is the earlier of the date of Clinical Diagnosis or the date the specimen used to diagnose Cancer is taken. If Cancer is first diagnosed while You are Hospitalized, You will be eligible for benefits retroactively, beginning with the date You were admitted to the Hospital, but not more than 30 days prior to the date of diagnosis. You will not be eligible for benefits for Hospitalizations which begin prior to the date You become insured under this policy.

EXCEPTION: If Skin Cancer is diagnosed while You are Hospitalized, You will be eligible for benefits only for the day(s) You actually received treatment for Skin Cancer.

While Your policy is in force, if Cancer is first diagnosed after You die, You will be eligible for benefits beginning on the date of admission for a period of continuous Hospitalization ending in Your death, but not for more than 30 days prior to the date of Your death.

Once treated for a diagnosed Cancer, You will no longer be eligible for Cancer benefits after the earlier of:

- the date that a Physician determines that there is no evidence of malignant cells, leukemia or Hodgkin's Disease, or
- five years following Your most recent diagnosis of Cancer. If five years have elapsed since Your most recent diagnosis of Cancer, You will continue to be eligible for Cancer benefits upon submission to the Company of a subsequent Pathological or Clinical Diagnosis of Cancer.

SECTION 3: BENEFITS

OUR PROMISE TO PAY: Subject to the terms, conditions, limitations and exclusions of this policy, We will pay the benefits described below. For benefits based on “charges up to” (the Anti-Nausea, Second Surgical Opinion, Prosthesis, Self-Administered Chemotherapy and Special Treatment benefits) if You do not receive a charge for Your treatment in a U.S. Government Hospital or any other medical facility, the benefit will not be paid.

FIRST OCCURRENCE – INTERNAL CANCER BENEFIT: We will pay **[$1,000/$2,000/$3,000]** when You are diagnosed for the first time, while insured under this policy, as having any internal Cancer. We will not pay this benefit for Skin Cancer. We will pay this benefit even when Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

FIRST OCCURRENCE – SKIN CANCER BENEFIT: We will pay **[$300/$600/$900]** when You are diagnosed for the first time, while insured under this policy, as having Skin Cancer. We will pay this benefit even when Skin Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

BREAST CANCER BENEFIT: We will pay **[$500/$1,000/$1,500]** when You are diagnosed for the first time, while insured under this policy, as having internal breast Cancer. We will not pay this benefit for Skin Cancer. We will

pay this benefit even when breast Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

PROSTATE CANCER BENEFIT: We will pay **[$500/$1,000/$1,500]** when You are diagnosed for the first time, while insured under this policy, as having prostate Cancer. We will pay this benefit even when prostate Cancer is diagnosed after Your death. We will pay this benefit only once for any insured person.

HOSPITALIZATION BENEFIT: We will pay **[$150/$300/$450]** for each day You are Hospitalized for Covered Cancer Treatment. The benefit will be calculated based on the number of days the Hospital charges You for room and board.

AMBULANCE BENEFIT: We will pay charges up to **[$200/$400/$600]** per one-way trip if a licensed surface or air ambulance service transports You to or from a Hospital where You are Hospitalized for Covered Cancer Treatment.

This benefit is limited to two one-way trips per Hospitalization.

RADIATION PLANNING BENEFIT: We will pay **[$100/$200/$300]** per day, up to a lifetime maximum of **[$300/$600/$900]**, for Your:

- radiation planning,
- dosimetry,
- simulation,
- design and construction of devices used for Your radiation treatment, and
- continuing physics.

We will determine whether this benefit is payable based on the Current Procedural Terminology (CPT) Code shown on Your bill.

RADIATION AND CHEMOTHERAPY BENEFIT: We will pay **[$100/$200/$300]** for each day that You receive one of the following:

- radiation treatments, or
- Chemotherapy delivered either intravenously, by injection, or by infusion, and delivered by a medical professional in a medical facility.

This benefit does not pay for diagnostic x-rays or planning procedures related to these therapy treatments. This benefit is not payable for any treatments paid under the Self-Administered Chemotherapy benefit or any of the benefits paid under the Radiation Planning Benefit.

SELF-ADMINISTERED CHEMOTHERAPY BENEFIT: In any Week that You do not receive the Radiation and Chemotherapy Benefit, We will pay charges up to **[$80/$160/$240]** per Week for Your prescriptions filled for self-administered Chemotherapy. If We pay this benefit and later find that a Radiation and Chemotherapy Benefit is payable for the same Week, We will recalculate Your benefits to pay You the higher amount payable under the Radiation and Chemotherapy Benefit. This benefit has a lifetime maximum of **[$10,000/$20,000/$30,000]**.

This benefit is not payable for any treatments paid under the Radiation and Chemotherapy Benefit.

ANTI-NAUSEA BENEFIT: We will pay charges up to **[$250/$500/$750]** per calendar year when You receive anti-nausea drugs that are prescribed by a Doctor while You are receiving radiation or Chemotherapy treatments. Oral anti-nausea medication will be limited to the cost of the prescription on the day You have the prescription filled, up to the benefit amount stated above.

SPECIAL TREATMENT BENEFIT: We will pay charges up to **[$500/$1,000/$1,500]** if You receive any of the following procedures:

- Immunotherapy;
- Stem Cell Transplant;
- Hormone Therapy;
- Autologous Bone Marrow Transplant;
- Radioimmunotherapy; and
- Photodynamic Therapy.

For treatments that are self administered, We will pay charges up to **[$500/$1,000/$1,500]** for the cost of the prescription on the day the prescription is filled.

These treatments must be approved for the treatment of Cancer by the U.S. Food and Drug Administration (FDA). The amount listed is the maximum payable per lifetime for each person insured by this policy.

SURGERY AND ANESTHESIA BENEFIT: We will pay this benefit for surgery performed by a Doctor to treat or diagnose Your Cancer. Anesthesia is not required for a surgery to be payable under this policy. We will use the Current Procedural Terminology (CPT) Code from Your bill and the Relative Value for that CPT Code shown in the 2009 Relative Values for Physicians to determine the benefit amount according to the schedule below:

Relative Value	Benefit Amount	Relative Value	Benefit Amount
0.0 – 7.9	[$100/$200/$300]	39.0 – 39.9	[$1,198/$2,396/$3,594]
8.0 – 8.9	[$110/$220/$330]	40.0 – 40.9	[$1,261/$2,522/$3,783]
9.0 – 9.9	[$127/$254/$381]	41.0 – 41.9	[$1,326/$2,652/$3,978]
10.0 – 10.9	[$145/$290/$435]	42.0 – 42.9	[$1,394/$2,788/$4,182]
11.0 – 11.9	[$163/$326/$489]	43.0 – 43.9	[$1,465/$2,930/$4,395]
12.0 – 12.9	[$183/$366/$549]	44.0 – 44.9	[$1,538/$3,076/$4,614]
13.0 – 13.9	[$203/$406/$609]	45.0 – 45.9	[$1,615/$3,230/$4,845]
14.0 – 14.9	[$225/$450/$675]	46.0 – 46.9	[$1,694/$3,388/$5,082]
15.0 – 15.9	[$247/$494/$741]	47.0 – 47.9	[$1,776/$3,552/$5,328]
16.0 – 16.9	[$270/$540/$810]	48.0 – 48.9	[$1,862/$3,724/$5,586]
17.0 – 17.9	[$295/$590/$885]	49.0 – 49.9	[$1,950/$3,900/$5,850]
18.0 – 18.9	[$321/$642/$963]	50.0 – 50.9	[$2,043/$4,086/$6,129]
19.0 – 19.9	[$348/$696/$1,044]	51.0 – 51.9	[$2,138/$4,276/$6,414]
20.0 – 20.9	[$375/$750/$1,125]	52.0 – 52.9	[$2,237/$4,474/$6,711]
21.0 – 21.9	[$404/$808/$1,212]	53.0 – 53.9	[$2,340/$4,680/$7,020]
22.0 – 22.9	[$435/$870/$1,305]	54.0 – 54.9	[$2,447/$4,894/$7,341]
23.0 – 23.9	[$466/$932/$1,398]	55.0 – 55.9	[$2,558/$5,116/$7,674]
24.0 – 24.9	[$500/$1,000/$1,500]	56.0 – 56.9	[$2,673/$5,346/$8,019]
25.0 – 25.9	[$534/$1,068/$1,602]	57.0 – 57.9	[$2,792/$5,584/$8,376]
26.0 – 26.9	[$570/$1,140/$1,710]	58.0 – 58.9	[$2,915/$5,830/$8,745]
27.0 – 27.9	[$608/$1,216/$1,824]	59.0 – 59.9	[$3,044/$6,088/$9,132]
28.0 – 28.9	[$647/$1,294/$1,941]	60.0 – 60.9	[$3,177/$6,354/$9,531]
29.0 – 29.9	[$687/$1,374/$2,061]	61.0 – 61.9	[$3,314/$6,628/$9,942]
30.0 – 30.9	[$730/$1,460/$2,190]	62.0 – 62.9	[$3,457/$6,914/$10,371]
31.0 – 31.9	[$774/$1,548/$2,322]	63.0 – 63.9	[$3,605/$7,210/$10,815]
32.0 – 32.9	[$820/$1,640/$2,460]	64.0 – 64.9	[$3,759/$7,518/$11,277]
33.0 – 33.9	[$868/$1,736/$2,604]	65.0 – 65.9	[$3,918/$7,836/$11,754]
34.0 – 34.9	[$917/$1,834/$2,751]	66.0 – 66.9	[$4,083/$8,166/$12,249]
35.0 – 35.9	[$969/$1,938/$2,907]	67.0 – 67.9	[$4,253/$8,506/$12,759]
36.0 – 36.9	[$1,023/$2,046/$3,069]	68.0 – 68.9	[$4,430/$8,860/$13,290]
37.0 – 37.9	[$1,079/$2,158/$3,237]	69.0 – 69.9	[$4,613/$9,226/$13,839]
38.0 – 38.9	[$1,137/$2,274/$3,411]	70.0 – 70.9	[$4,803/$9,606/$14,409]
		71.0 +	[$5,000/$10,000/$15,000]

We will not pay for reconstructive, diagnostic, hormone related or follow-up surgery which does not definitively diagnose or treat Cancer. EXCEPTION: We will pay for reconstructive breast surgery under the Reconstructive Breast Surgery Benefit.

If two or more surgical procedures are performed on the same day, We will pay only for one surgery, the one with the highest Relative Value. For any surgery, We will pay no less than **[$100/$200/$300]** and no more than **[$5,000/$10,000/$15,000]**.

If We do not receive a CPT code for Your surgery from Your surgeon or the Hospital where it was performed, this benefit will not be paid. If We receive a CPT code from Your surgeon or the Hospital, but it is not listed in the 2009 Relative Values for Physicians, We will substitute another reasonable method of determining the benefit amount based on a comparison of Your surgery to the surgeries that are listed in the 2009 Relative Values for Physicians.

RECONSTRUCTIVE BREAST SURGERY BENEFIT: We will pay **[$250/$500/$750]** for each breast for reconstructive breast surgery following a mastectomy. We will also pay **[$250/$500/$750]** for one reconstructive surgery on a non-diseased breast to establish symmetry with a diseased breast. This benefit has a lifetime maximum of **[$500/$1,000/$1,500]** per person.

SECOND SURGICAL OPINION BENEFIT: We will pay charges up to **[$200/$400/$600]** if any covered person receives a second surgical opinion concerning Cancer surgery for a diagnosed Cancer by a licensed Physician. The second surgical opinion must occur after diagnosis and before surgery. This benefit is limited to one second opinion per surgery.

BONE MARROW TRANSPLANT BENEFIT: We will pay **[$5,000/$10,000/$15,000]** for a human bone marrow transplant that You receive for the treatment of leukemia. This benefit includes medical expenses for the bone marrow transplant and the medical expenses for the donor. We will pay this benefit no more than once for any insured person.

A human bone marrow transplant is an allogeneic or syngeneic graft of living bone marrow from one human being to another. We will not pay this benefit for autologous bone marrow transplants (when You act as Your own donor) for the implantation of artificial or synthetic bone marrow or for Stem Cell Transplants.

BONE MARROW DONOR BENEFIT: We will pay **[$1,000/$2,000/$3,000]** if You donate Your own bone marrow to another person who is receiving treatment for Cancer. We will pay this benefit no more than once for any insured person.

PROSTHESIS BENEFIT: We will pay charges up to **[$1,000/$2,000/$3,000]** for prosthetic devices which are prescribed as a direct result of Covered Cancer Treatment. The amount listed is the maximum payable per lifetime for each person insured by this policy.

WELLNESS BENEFIT: We will pay up to a maximum of **[$50/$100/$150]** per calendar year for each insured person based on the following:

- **[$50/$100/$150]** for a colonoscopy, or completion of Tobacco Cessation as described below;
- **[$40/$80/$120]** for a flexible sigmoidoscopy, barium enema, breast ultrasound, transvaginal ultrasound, or human papillomavirus (HPV) vaccine;
- **[$30/$60/$90]** for a mammography, sputum cytology, or urine cytology;
- **[$25/$50/$75]** for a pap smear, CEA, CA 125 assay, fecal occult stool specimen or prostate specific antigen test.

The HPV benefit is payable only once during the lifetime of any insured. The Tobacco Cessation benefit is only payable for the Policyowner or covered Spouse and only once during their lifetime.

Except for Tobacco Cessation, any of the above items must be administered by a medical professional for the purpose of screening or testing for the presence of Cancer. No diagnosis of Cancer is required for this benefit to be payable. This benefit is not subject to the 30-day Waiting Period.

To receive a benefit for Tobacco Cessation, You must first notify the Company of Your intent to quit using tobacco products. We will send You the necessary forms to establish a “quit date”. Payment of the benefit will only be made after You have provided Us with a certification that You have ceased using tobacco products for six consecutive months after the established quit date.

HOSPICE BENEFIT: We will pay **[$50/$100/$150]** per day for each day You receive care provided by or through a Hospice as a direct result of Your Cancer. This benefit is limited to **[$9,000/$18,000/$27,000]** per insured person. You must be diagnosed as terminally ill, no longer be receiving Covered Cancer Treatment and be expected to live six months or less.

We will pay this amount for each day You:

- receive Hospice services in Your home;
- use the services of a Hospital on an outpatient basis under the direction of a Hospice; or,
- visit or are confined to a Hospice for treatment or services.

We will not pay this benefit for any day You are an inpatient in a Hospital.

TRANSPORTATION BENEFIT: We will pay this benefit if You must travel to a Destination that is more than 80 miles one-way from Your residence for:

- Covered Cancer Treatments prescribed by Your local Physician that are not available where You live; or
- up to 3 appointments with a Physician concerning Your Cancer diagnosis that occur before Your Covered Cancer Treatment begins.

For Your travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the Destination We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip. For Your travel by automobile We will pay **[20 cents/40 cents/60 cents]** for each mile You travel. To determine the mileage We will measure the distance traveled from where You live to the Destination by using the most direct route.

FAMILY MEMBER TRANSPORTATION BENEFIT: We will pay this benefit if You are eligible for the Transportation Benefit and a Family Member also travels to the Destination where You are Hospitalized as an inpatient for Covered Cancer Treatment. We will also pay this benefit if You are eligible for the Transportation Benefit and a Family Member also travels to the Destination for up to 3 appointments with a Physician concerning Your Cancer diagnosis that occur before Your Covered Cancer Treatment begins.

For Your Family Member's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the Destination We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip; or for travel by automobile (when the Family Member resides more than 80 miles one-way from the Destination) We will pay **[20 cents/40 cents/60 cents]** for each mile the Family Member travels. To determine the mileage We will measure the distance traveled from where the Family Member lives to the Destination by using the most direct route.

This benefit is limited to one Family Member making one round trip or two one-way trips for each time We pay the Transportation Benefit. "Family Member" means Your Spouse, parent, grandparent, grandchild, brother, sister or Child. The mileage benefit is not payable if the Family Member travels in the same automobile with You.

SECOND PARENT TRANSPORTATION BENEFIT: We will pay this benefit if You are eligible for the Family Member Transportation Benefit and a second parent also travels to the Destination under the following conditions:

- a covered Child is Hospitalized as an inpatient for Covered Cancer Treatment;
- this is a Family Policy;
- the Transportation Benefit is payable for a covered Child;
- the Family Member Transportation Benefit is payable for the other parent; and
- the Destination is more than 80 miles one-way from where the second parent lives.

For the second parent's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the Destination We will pay charges up to **[$1,000/$2,000/$3,000]** per round trip; or for travel by automobile We will pay **[20 cents/40 cents/60 cents]** for each mile the second parent travels. To determine the mileage We will measure the distance traveled from where the second parent lives to the Destination by using the most direct route. The mileage benefit is not payable if the second parent travels in the same automobile with You.

FAMILY MEMBER LODGING BENEFIT: We will pay charges up to **[$50/$100/$150]** for a Family Member's lodging in a hotel or motel under the following conditions:

- You are Hospitalized as an inpatient for Covered Cancer Treatment; and
- Your Family Member also travels to the Destination that is 80 miles one-way from where You and Your Family Member live.

"Family Member" means Your Spouse, parent, grandparent, grandchild, brother, sister or Child. This benefit is limited to payment for one hotel or motel room for each day of Your Hospitalization, up to a maximum of 60 days for each period of Hospitalization during which the Hospitalization Benefit is payable under this policy.

RETURN OF PREMIUM BENEFIT: You will be eligible for the Return of Premium Benefit if You keep Your policy in force until the Return of Premium Maturity Date. You are not required to surrender Your policy on the Return of Premium Maturity Date to receive this benefit.

The benefit amount is equal to the Premiums paid while this policy was in force minus any Claims Incurred prior to the Return of Premium Maturity Date. Premiums paid for any rider will be included in the benefit amount only if that rider is in force on the Return of Premium Maturity Date.

If this is an Individual Policy or Single Parent Policy and the Policyowner dies while this policy is in force and prior to the Return of Premium Maturity Date, We will pay a benefit amount equal to the Premiums paid while this policy was in force, minus any Claims Incurred while this policy was in force. We will pay this benefit upon Our receipt of proof of the Policyowner's death.

If this is a Family Policy or Married Couple Policy and the Policyowner and Spouse both die while this policy is in force and prior to the Return of Premium Maturity Date, We will pay a benefit amount equal to the Premiums paid while this policy was in force, minus any Claims Incurred while this policy was in force. We will pay this benefit upon Our receipt of proof of the Policyowner and Spouse's death.

SECTION 4: LIMITATIONS AND EXCLUSIONS

CANCER TREATMENT ONLY: This policy provides benefits only for loss due to Cancer and for Your Covered Cancer Treatment which occurs more than 30 days after the Effective Date of Your policy.

SECTION 5: GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the application, Policy Schedule, and any attached riders, amendments or endorsements constitutes the entire contract of insurance. No change to this policy is valid until approved and endorsed by one of Our Executive officers and attached to this policy. No agent has authority to change this policy or to waive any of its provisions.

CHANGE OF BENEFICIARY: The right to change of Beneficiary is reserved to the Policyowner and the Policyowner can ask Us to change the Beneficiary at any time. The consent of the Beneficiary or Beneficiaries will not be required in order to change the Beneficiary or to make any other changes in this policy. The Policyowner's request must be in writing and the change must be approved by Us. If approved, it will go into effect the day the Policyowner signs the request. The change will not have any bearing on payments made before We received the request.

TERM: This policy becomes effective at 12:00 noon (Eastern Standard Time) on the Effective Date shown on Your Policy Schedule. Each renewal term ends at 12:00 noon (Eastern Standard Time) on the date to which Your Premium is paid. Renewal dates are determined by mode of payment. Your initial mode of payment is shown on Your Policy Schedule.

PREMIUMS: The first Premium is due on the Effective Date. Each Premium after the first is due on the last day of the term for which the most recent Premium was paid and must be paid to Us at Our Executive Office.

This policy will not be in force until Your Effective Date and both Your application is approved and the first Premium is accepted by Us. If We accept subsequent Premium, this policy will continue in force until the end of the term for which the Premium is due.

The amount of the first Premium for the initial mode of payment is shown in the Policy Schedule. The amount of each Premium after the first is based on Your then current mode of payment.

UNEARNED PREMIUM: If the Policyowner dies and the policy is not continued by the covered Spouse as described under the Continuation provision, any proceeds payable to the Policyowner's estate will include Premiums paid for any period beyond the end of the policy month in which the death occurred. Unearned Premiums shall be paid in a lump sum on a date no later than 30 days after the proof of the Policyowner's death has been furnished to Us.

GRACE PERIOD: If You do not pay a Premium when it is due, You can pay it during the next 31 days. During this grace period the policy will stay in force and will terminate if You do not pay the Premium by the end of the grace period.

CANCELLATION OF INSURANCE: The Policyowner may cancel this policy at any time. The Policyowner's request must be in writing and sent to Us at Our Executive Office. Cancellation will become effective on the day We receive the request, or on a later date specified in Your request. In the event of cancellation We will promptly return the unearned portion of any Premium paid. This will be calculated using the pro-rata portion of any Premium

paid. If any claim originated prior to the effective date of cancellation, We will pay the appropriate benefits due. We cannot cancel this policy for any reason other than nonpayment of Premium.

REINSTATEMENT: If this policy terminates because You do not pay the Premium by the end of the grace period, You may be able to put Your insurance back in force.

If We or Our authorized agent accept Your Premium and do not require a reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date We receive the Premium. If We or Our authorized agent require a reinstatement application at the time We accept the Premium, We will issue You a conditional receipt for the Premium. Upon Our receipt and approval of the reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date the reinstatement application is approved. If We do not mail written notice of disapproval of the reinstatement application within 45 days of the date of the conditional receipt, then this policy will automatically be reinstated as of 12:00 noon (Eastern Standard Time) on the 45th day.

The reinstated policy will cover only loss due to Cancer which is first diagnosed more than 10 days after the reinstatement date. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium was due but not to a period of more than 60 days prior to the date of reinstatement.

If an Intensive Care Unit Rider is included in this policy, the rider will not provide benefits for Hospitalization, whether or not in an Intensive Care Unit, which begin prior to the reinstatement date.

We reserve the right to make changes to this policy before We reinstate it. Any changes will be noted on or attached to the reinstated policy. In every other way, Your rights and Our rights will be the same.

CONTINUATION: In the event of the Policyowner's death, the Spouse, if covered under the policy, shall become the Policyowner. We will need proof of the Policyowner's death (a death certificate) in order to make this change.

CONVERSION: If the Policyowner's Spouse is covered under this policy and would lose insurance because of divorce or annulment, or a covered dependent Child would lose insurance because of marriage, attainment of the limiting age or the Policyowner's death, then Your Spouse and/or Child may convert to a separate policy. A written request for conversion, along with the appropriate Premium, must be sent to Our Executive Office within 60 days after the date insurance would otherwise end. We will issue, without evidence of insurability, an equal or similar policy. The converted insurance will be limited by any exclusions which applied under this policy. Additionally, any benefit amounts paid for a person under this policy will be applied to benefit limits under that person's converted policy.

CHANGE IN COVERAGE: If You are diagnosed with Cancer within 30 days following an increase in Your coverage, We will charge Premiums and pay benefits at Your prior level of coverage.

MISSTATEMENTS OF AGE: If any age or date of birth is misstated in the application, benefit amounts will be determined based on the appropriate age at the time coverage was purchased. If, based on the correct ages, We would not have issued this policy or insured certain members of Your family under this policy, then Our only responsibility will be to refund any excess Premium paid.

TIME LIMIT ON CERTAIN DEFENSES: After Your insurance has been in force for three years, We cannot deny a claim or void the policy due to a misstatement, except a fraudulent misstatement, made by the applicant in the application.

No claim for loss incurred after three years from the date You become insured under this policy will be reduced or denied on the ground that a disease or physical condition not excluded by name or specific description existed prior to the Effective Date of Your insurance.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on the Effective Date, is in conflict with the laws of the state in which Your policy was issued, will be amended to conform to the minimum requirements of those laws.

SECTION 6: CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of a claim must be given to Us within 60 days after the start of a covered loss or as soon thereafter as reasonably possible. Notice given by or on behalf of the Policyholder or Beneficiary to Us at P.O. Box 470608, Cleveland, Ohio 44147 with information sufficient to identify the Policyholder will be deemed notice of claim to Us.

CLAIM FORMS: When We receive notice of a claim, We will send forms for filing proof of loss. If these forms are not sent within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.

PROOFS OF LOSS: Written proof of loss must be furnished to Us in English at Our Executive Office within 90 days after the loss for which You are seeking benefits. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within that time provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

One or more of the following together with Your written statement or Power of Attorney may be required as proof of loss:

- a Pathologist's report;
- an autopsy report;
- a Physician's statement;
- itemized bills for purchases or services rendered;
- Hospital, medical and Physician records;
- completed Company claim forms;
- adoption papers, birth, marriage or death certificates;
- medical and pharmaceutical receipts; and
- transportation and lodging receipts.

TIME OF PAYMENT OF CLAIMS: Benefits for any loss covered by this policy will be paid immediately upon Our receipt of due written proof of loss.

PAYMENT OF CLAIMS: Benefits will be paid directly to the Policyowner. Any benefits unpaid at the time of the Policyowner's death will be paid in the following order: to any approved assignee, to the Beneficiary or to the Policyowner's estate.

EXTENSION OF BENEFITS: Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force but the extension of benefits beyond the period the policy was in force may be predicated upon the payment of the maximum benefits.

ASSIGNMENT OF BENEFITS: We will not be bound by any assignment of benefits request or authorization form unless We have given Our prior consent.

UNPAID PREMIUM: When a claim is paid, any Premium due and unpaid may be deducted from Your claim payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have You examined as often as reasonably necessary while a claim is pending. We can require an autopsy where allowed by law. Either will be done at Our expense.

LEGAL ACTION: You cannot take legal action against Us under this policy:

- within 60 days after You have sent Us written proof of loss; or,
- more than three years from the time written proof is required to be given.

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

Executive Office: P.O. Box 470608, Cleveland, Ohio 44147

SPECIFIED DISEASE COVERAGE – CANCER ONLY

THIS POLICY PROVIDES LIMITED BENEFITS.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE

Policy Form Series C8POLR

This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

PLEASE READ YOUR OUTLINE OF COVERAGE CAREFULLY

This outline of coverage provides a very brief description of the important features of your coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

SPECIFIED DISEASE – CANCER ONLY COVERAGE

Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

DESCRIPTION OF BENEFITS

FIRST OCCURRENCE – INTERNAL CANCER BENEFIT: [$1,000/$2,000/$3,000] when you are diagnosed for the first time, while insured under the policy, as having any internal cancer. This benefit is not payable for skin cancer. This benefit is payable only once for any insured person.

FIRST OCCURRENCE – SKIN CANCER BENEFIT: [$300/$600/$900] when you are diagnosed for the first time, while insured under the policy, as having skin cancer. This benefit is payable only once for any insured person.

BREAST CANCER BENEFIT: [$500/$1,000/$1,500] when you are diagnosed for the first time, while insured under the policy, as having internal breast cancer. This benefit is not payable for skin cancer. This benefit is payable only once for any insured person.

PROSTATE CANCER BENEFIT: [$500/$1,000/$1,500] when you are diagnosed for the first time, while insured under the policy, as having prostate cancer. We will pay this benefit only once for any insured person.

PLEASE RETAIN THIS FOR YOUR RECORDS

HOSPITALIZATION BENEFIT: [$150/$300/$450] for each day you are hospitalized as an inpatient for covered cancer treatment. The benefit will be calculated based on the number of days the hospital charges for room and board.

AMBULANCE BENEFIT: Charges up to **[$200/$400/$600]** per one-way trip if a licensed surface or air ambulance service transports you to or from a hospital where you are hospitalized as an inpatient for covered cancer treatment. This benefit is limited to two one-way trips per inpatient hospitalization.

RADIATION PLANNING BENEFIT: [$100/$200/$300] per day, up to a lifetime maximum of **[$300/$600/$900]**, for radiation planning, dosimetry, simulation, design and construction of devices used for radiation treatment, and continuing physics. Payment of this benefit is determined based on the Current Procedural Terminology (CPT) code shown on the patient's bill.

RADIATION AND CHEMOTHERAPY BENEFIT: [$100/$200/$300] for each day that you receive radiation treatments, or chemotherapy delivered either intravenously, by injection, or by infusion, and delivered by a medical professional in a medical facility. This benefit does not pay for diagnostic x-rays or planning procedures related to these therapy treatments. This benefit is not payable for any treatments paid under the Self-Administered Chemotherapy benefit or any of the benefits paid under the Radiation Planning Benefit.

SELF-ADMINISTERED CHEMOTHERAPY BENEFIT: In any week that you do not receive the Radiation and Chemotherapy Benefit, this benefit will pay charges up to **[$80/$160/$240]** per week for prescriptions filled for self-administered chemotherapy. If this benefit is paid and we later find that a Radiation and Chemotherapy Benefit is payable for the same week, we will recalculate these benefits to pay you the higher amount payable under the Radiation and Chemotherapy Benefit. This benefit has a lifetime maximum of **[$10,000/$20,000/$30,000]**. This benefit is not payable for any treatments paid under the Radiation and Chemotherapy Benefit.

ANTI-NAUSEA BENEFIT: Charges up to **[$250/$500/$750]** per calendar year for anti-nausea drugs that are prescribed by a doctor while you are receiving radiation or chemotherapy treatments. Oral anti-nausea medication will be limited to the cost of the prescription on the day the prescription is filled, up to the benefit amount stated above.

SPECIAL TREATMENT BENEFIT: Charges up to **[$500/$1,000/$1,500]** for Immunotherapy; Stem Cell Transplant; Hormone Therapy; Autologous Bone Marrow Transplant; Radioimmunotherapy; and Photodynamic Therapy. For treatments that are self administered, charges up to **[$500/$1,000/$1,500]** for the cost of the prescription on the day the prescription is filled. These treatments must be approved for the treatment of cancer by the U.S. Food and Drug Administration. The amount listed is the maximum payable per lifetime for each person insured by this policy.

SURGERY AND ANESTHESIA BENEFIT: This benefit is payable for surgery performed by a doctor to treat or diagnose cancer. We will use the Current Procedural Terminology (CPT) Code from the patient's bill and the Relative Value for that CPT Code shown in the 2009 Relative Values for Physicians to determine the benefit amount according to the schedule in the policy. This benefit is not payable for reconstructive, diagnostic, hormone related or follow-up surgery which does not definitively diagnose or treat cancer. EXCEPTION: Reconstructive breast surgery is payable under the Reconstructive Breast Surgery Benefit.

If two or more surgical procedures are performed on the same day, only one surgery will be payable, the one with the highest Relative Value. For any surgery, we will pay no less than **[$100/$200/$300]** and no more than the **[$5,000/$10,000/$15,000]**.

If we do not receive a CPT code for your surgery from the surgeon or the hospital where it was performed, this benefit will not be paid. If we receive a CPT code from the surgeon or the hospital, but it is not listed in the 2009 Relative Values for Physicians, we will substitute another reasonable method of determining the benefit amount based on a comparison of the surgery to the surgeries that are listed in the 2009 Relative Values for Physicians.

RECONSTRUCTIVE BREAST SURGERY BENEFIT: [$250/$500/$750] for each breast for reconstructive breast surgery following a mastectomy. **[$250/$500/$750]** is also payable for one reconstructive surgery on a non-diseased breast to establish symmetry with a diseased breast. This benefit has a lifetime maximum of **[$500/$1,000/$1,500]** per person.

SECOND SURGICAL OPINION BENEFIT: Charges up to **[$200/$400/$600]** if any covered person receives a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician. The second surgical opinion must occur after diagnosis and before surgery. This benefit is limited to one second opinion per surgery.

BONE MARROW TRANSPLANT BENEFIT: [$5,000/$10,000/$15,000] for a human bone marrow transplant for the treatment of leukemia. This benefit includes medical expenses for the bone marrow transplant and the medical expenses for the donor. We will pay this benefit no more than once for any insured person. This benefit is not payable for autologous bone marrow transplants (when you act as your own donor) for the implantation of artificial or synthetic bone marrow or for stem cell transplants.

BONE MARROW DONOR BENEFIT: [$1,000/$2,000/$3,000] if you donate your own bone marrow to another person who is receiving treatment for cancer. We will pay this benefit no more than once for any insured person.

PROSTHESIS BENEFIT: Charges up to **[$1,000/$2,000/$3,000]** for prosthetic devices which are prescribed as a direct result of covered cancer treatment. The amount listed is the maximum payable per lifetime for each person insured by this policy.

WELLNESS BENEFIT: Up to a maximum of **[$50/$100/$150]** per calendar year for each insured person based on the following:

- **[$50/$100/$150]** for a colonoscopy, or completion of Tobacco Cessation as described below;
- **[$40/$80/$120]** for a flexible sigmoidoscopy, barium enema, breast ultrasound, transvaginal ultrasound, or human papillomavirus (HPV) vaccine;
- **[$30/$60/$90]** for a mammography, sputum cytology, or urine cytology;
- **[$25/$50/$75]** for a pap smear, CEA, CA 125 assay, fecal occult stool specimen or prostate specific antigen test.

The HPV benefit is payable only once during the lifetime of any insured. The Tobacco Cessation benefit is only payable for the Policyowner or covered Spouse and only once during their lifetime.

Except for Tobacco Cessation, any of the above items must be administered by a medical professional for the purpose of screening or testing for the presence of cancer. No diagnosis of cancer is required for this benefit to be payable. This benefit is not subject to the 30-day Waiting Period.

HOSPICE BENEFIT: [$50/$100/$150] per day for each day that care is provided by or through a hospice as a direct result of cancer. This benefit is limited to **[$9,000/$18,000/$27,000]** per insured person. You must be diagnosed as terminally ill, no longer be receiving covered cancer treatment and be expected to live six months or less.

This benefit will be payable for each day you receive hospice services in your home, use the services of a hospital on an outpatient basis under the direction of a hospice, or visit or are confined to a hospice for treatment or services. We will not pay this benefit for any day you are an inpatient in a hospital.

TRANSPORTATION BENEFIT: This benefit is payable for travel to a hospital or a comprehensive or clinical cancer center that is more than 80 miles one-way from your residence for covered cancer treatments prescribed by a local physician that are not available where you live; or up to 3 appointments with a physician concerning your cancer diagnosis that occur before your covered cancer treatment begins.

For travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the hospital or cancer center this benefit pays charges up to **[$1,000/$2,000/$3,000]** per round trip. For travel by automobile this benefit pays **[20 cents/40 cents/60 cents]** for each mile traveled.

FAMILY MEMBER TRANSPORTATION BENEFIT: This benefit is payable if you are eligible for the Transportation Benefit and a family member also travels to the hospital or cancer center where you are hospitalized as an inpatient for covered cancer treatment. "Family member" means your spouse, parent, grandparent, grandchild, brother, sister or child. We will also pay this benefit if you are eligible for the Transportation Benefit and a family member also travels to the hospital or cancer center for up to 3 appointments with a physician concerning your cancer diagnosis that occur before covered cancer treatment begins.

This benefit pays charges up to **[$1,000/$2,000/$3,000]** per round trip for a family member's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the hospital or cancer center. Or, for travel by automobile (when the family member resides more than 80 miles one-way from the hospital or cancer center) this benefit pays **[20 cents/40 cents/60 cents]** for each mile the family member travels.

This benefit is limited to one family member making one round trip or two one-way trips for each time the Transportation Benefit is paid. The mileage benefit is not payable if the family member travels in the same automobile with the patient.

SECOND PARENT TRANSPORTATION BENEFIT: This benefit is payable if you are eligible for the Family Member Transportation Benefit and a second parent also travels to the hospital or cancer center under the following conditions:

- a covered child is hospitalized as an inpatient for covered cancer treatment;
- this is a family policy;
- the Transportation Benefit is payable for a covered child;
- the Family Member Transportation Benefit is payable for the other parent; and
- the hospital or cancer center is more than 80 miles one-way from where the second parent lives.

For the second parent's travel by coach class airplane, train or bus fare on a regularly scheduled commercial route to the hospital or cancer center this benefit pays charges up to **[$1,000/$2,000/$3,000]** per round trip. Or, for travel by automobile this benefit pays **[20 cents/40**

cents/60 cents] for each mile the second parent travels. The mileage benefit is not payable if the second parent travels in the same automobile with the patient.

FAMILY MEMBER LODGING BENEFIT: This benefit pays charges up to **[$50/$100/$150]** for a family member's lodging in a hotel or motel under the following conditions:

- you are hospitalized as an inpatient for covered cancer treatment; and
- your family member also travels to the hospital or cancer center that is 80 miles one-way from where you and your family member live.

This benefit is limited to payment for one hotel or motel room for each day of hospitalization, up to a maximum of 60 days for each period of hospitalization during which the Hospitalization Benefit is payable under this policy.

RETURN OF PREMIUM BENEFIT: This benefit is payable if the policy is kept in force until the Return of Premium Maturity Date (either the 20th Policy Anniversary Date or the date when we receive 20 full years of premium, whichever is later). The benefit amount is equal to the premiums paid while this policy was in force minus any claims incurred prior to the Return of Premium Maturity Date. Premiums paid for any rider will be included in the benefit amount only if that rider is in force on the Return of Premium Maturity Date.

If this is an Individual Policy or Single Parent Policy and the Policyowner dies while this policy is in force and prior to the Return of Premium Maturity Date, we will pay a benefit amount equal to the premiums paid while this policy was in force, minus any claims incurred while this policy was in force. We will pay this benefit upon our receipt of proof of the Policyowner's death.

If this is a Family Policy or Married Couple Policy and the Policyowner and Spouse both die while this policy is in force and prior to the Return of Premium Maturity Date, we will pay a benefit amount equal to the premiums paid while this policy was in force, minus any claims Incurred while this policy was in force. We will pay this benefit upon our receipt of proof of the Policyowner and Spouse's death.

LIMITATIONS AND EXCLUSIONS

This policy provides benefits only for loss due to cancer and for your covered cancer treatment which occurs more than 30 days after the effective date of your policy.

RENEWABILITY

This policy is renewable for life. Rates may be changed only if changed on all policies of this kind in your state.

COVERAGE

Benefit dollar amounts are stated throughout this Outline of Coverage in the following order from left to right: **Standard Level/Preferred Level/Elite Level.**

You have applied for the ☐ **Standard** ☐ **Preferred** ☐ **Elite** benefit level.

PLEASE RETAIN THIS FOR YOUR RECORDS